Evaluation of the Grant Program for Rural Health Care Transition
1995 Annual Progress Report

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Report to Congress
1995

U.S. Department of Health and Human Services
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EXECUTIVE SUMMARY

Congress charged the Health Care Financing Administration (HCFA) with implementing a program of Rural Health Care Transition (RHCT) grants.[1] The goal of this program is to help small rural hospitals (those with fewer than 100 beds) improve their financial stability and management capacity.

HCFA implemented the program in September 1989 with 184 grantee hospitals; additional hospitals received grants in each subsequent September. Since the program began, 1,053 RHCT grants have been awarded: 184 in 1989, 212 in 1990, 187 in 1991, 163 in 1992, 178 in 1993, and 129 in 1994. Nearly 45 percent of the small rural hospitals in the United States have received program grants, and Congress has authorized $117 million in grant program funding during the past 6 years.

The 1989, 1990, and 1991 grantees completed their grant projects in September 1992, September 1993, and September 1994, respectively. Currently, 444 active grantees are progressing with their projects over the 3-year grant period.

Current legislation mandates that the HCFA administrator report on the program's progress to Congress annually. Here, we focus on two topics: (1) comparing characteristics of 1993 grantees at award with those of earlier cohorts; and (2) understanding how a low-income location affects grantee financial stability. We also describe the progress of the 1992 grantees after 21 months, the 1993 grantees after 6 months, and the selection of 1994 grantees.

1993 GRANTEE CHARACTERISTICS COMPARED WITH THOSE OF EARLIER COHORTS

The characteristics of participants in an established, ongoing program may differ from the characteristics of participants in a new and unfamiliar program. Over time, new programs may gain publicity from program success or from the word-of-mouth of participants. This program validation by early participants may convince less willing or less able participants to apply to the program. As a result, we might expect participants in the later years of a new program to have, for example, smaller staffs or more tenuous financial performance than participants in the first few years of a new program. We compared the characteristics at award of grantees from 1989 through 1993 to examine whether the characteristics of grantees at award have changed.

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[1] Omnibus Budget Reconciliation Act of 1987: P.L. 100-203.

In general, the 1993 grantees resembled the earlier cohorts. The small differences between the cohorts reflect year-to-year variation we expect in the grant program. Like earlier cohorts, most of the 1993 grantees were owned either by a county or hospital district or operated as private, nonprofit organizations and were not under contract management or part of a multihospital system.

Grantees in all cohorts had favorable balance sheets but unfavorable income flows. Although grantees generally reported twice as many assets as liabilities, they lost between one and four percent of net patient revenue on operations. Grantees usually recovered this shortfall from nonoperating revenues. However, the overall picture masks important variation within cohorts. For example, 22 percent of 1993 grantees were having serious financial problems because of losses on operations, as well as ratios of current assets to current liabilities that were too small to manage cash flow easily. In addition, grantees with fewer than 32 beds had the worst financial measures.

Grantees' general financial condition remained the same over the five cohorts, but the fraction with special reimbursement status clearly increased, reflecting a nationwide trend. Almost 50 percent of the 1993 grantees qualified as sole community hospitals, and approximately 28 percent qualified as disproportionate share hospitals. Earlier cohorts had smaller proportions qualifying for special reimbursement status; for example, in 1989, only 21 percent of grantees qualified as sole community hospitals, and 9 percent qualified as disproportionate share hospitals.[2]

Grantees in all cohorts had small numbers of staff, but 1991, 1992, and 1993 grantees were more likely than 1989 or 1990 grantees to employ physician assistants. On average, grantees in all cohorts employed between 21 and 24 full-time equivalent registered nurses. In 1989, only six percent employed physician assistants. Subsequently, larger proportions of grantees reported employing physician assistants; by 1993, 19 percent reported doing so. The nationwide proliferation of Rural Health Clinics, which employ midlevel practitioners such as physician assistants, may account for this change in two ways. First, hospitals need to hire midlevel practitioners, such as physician assistants, in order to qualify their clinics as Rural Health Clinics. Second, the proliferation of independently-operated Rural Health Clinics may have familiarized hospitals with the abilities of physician assistants and thus, led more hospitals to employ these providers.

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[2] Sole community hospitals are the sole source of inpatient care for a geographic area because of weather or travel conditions, or the absence of other hospitals within 35 miles. Disproportionate share hospitals serve a disproportionate share of low-income patients, relative to other hospitals in the country. Medicare provides higher reimbursements for inpatient services provided by hospitals with either of these special designations. Medicaid makes additional payments to hospitals with disproportionate share status.

Larger proportions of recent grantees reported recruiting physicians, while smaller proportions reported recruiting registered nurses and licensed practical nurses. In 1989, only 56 percent of grantees reported recruiting physicians. In subsequent years, larger proportions reported doing so and, in 1993, all but one grantee reported recruiting physicians. In contrast, 79 percent reported recruiting registered nurses in 1989, and smaller proportions of grantees reported doing so in subsequent years. In 1993, only 48 percent reported recruiting registered nurses. The proportion of grantees recruiting licensed practical nurses followed the same pattern.

The service area characteristics of grantees in 1993 generally paralleled those of earlier cohorts, except for travel time by automobile to bigger hospitals. Grantees in all cohorts were important health care providers in their communities; often they were the only provider in the community. In addition, between 20 and 30 percent of all cohorts reported problems with access to nursing home beds or skilled home health nurses. Yet, 1992 and 1993 grantees were more isolated than 1989, 1990, and 1991 grantees from tertiary or urban hospitals. Typically, 1989, 1990, and 1991 grantees were 67 to 75 minutes away from the nearest tertiary hospital; later cohorts were 80 to 90 minutes away. A similar pattern occurred for travel time to an urban hospital.

Grantees in 1993, like earlier grantees, had low occupancy rates. They reported between 29 and 35 staffed acute-care beds across cohorts, with occupancy rates of between 36 and 42 percent.

Grantees in 1993 were far more likely than their counterparts in early cohorts to have swing beds. Greater proportions had swing beds available in each successive year between 1989 and 1993. In 1989, only 66 percent offered swing beds. By 1993, that proportion had gradually increased to 77 percent.

A small proportion of grantees in each cohort considered conversion to a different type of health care facility, consolidation with another hospital, or closure. Fourteen percent of the 1993 grantees considered conversion to another type of health care facility; 8 percent considered consolidation with another hospital, and 16 percent considered closure. A similar proportion of grantees in 1989 considered conversion or closure (17 percent and 15 percent, respectively), and a slightly higher proportion (14 percent) considered consolidation with another hospital.

HOW LOW-INCOME LOCATION AFFECTS FINANCIAL VIABILITY

Hospitals' dual interest in serving the community and remaining financially viable--that is, balancing their mission with their margin--is strikingly evident among the grantees in poor areas. Many of these hospitals face serious financial challenges, and equally serious health care needs exist in their communities. To explore how small rural hospitals survive financially in low-income communities and the role of the grant project in their viability, we conducted telephone interviews with 37 grantees in the counties with the lowest per-capita incomes.

The low-income grantees are located primarily in the South. Per-capita income for 1990 averaged $10,755 for the counties served by interviewed grantees, more than 30 percent lower than the average in counties nationwide with a small rural hospital. Twenty-four of these grantees reported no changes in their economies during the past five years, and 23 expect no changes in the near future. The economies of a majority of the low-income grantees rely on small manufacturing, agriculture or forestry, and correctional facilities.

While these hospitals are located in significantly poorer communities than the average grantee, their financial status is not markedly different from that of grantees overall. Thirteen had a positive operating margin during the past 3 years, 10 broke even, and 14 reported a loss on operations. The median operating margin of 1992 and 1993 grantees is one percent, a roughly comparable number. However, hospitals that are in poor financial shape tend to be smaller and have high levels of uncompensated care.

Medicaid patients and those without the means to pay for care make up sizable portions of the low-income grantees' business. On average, Medicaid accounted for approximately 20 percent of the operating revenues of low-income grantees. Some interviewed grantees reported receiving as much as 50 percent of their operating revenue from Medicaid. The average rural hospital nationwide reported receiving approximately 15 percent of its operating revenue from Medicaid. In addition, interviewed grantees reported that uncompensated care typically equals 11 percent of operating revenue; nationwide, uncompensated care represents approximately 5 percent of operating costs.

Seven of the 22 interviewed grantees with disproportionate share status consider these additional payments an important means of financial support. Disproportionate share payments range from $70,000 to more than $800,000 per year. Half of the seven hospitals have seen their payments reduced or eliminated during the past 2 years.

Despite the draining effects of being located in a low-income county, 13 of the interviewed grantees maintain their financial viability without direct subsidies from local government, the community, or a multihospital system. A substantial proportion of financially troubled hospitals rely on subsidies. Sixteen of the 24 hospitals with a negative operating margin receive tax support from local government, usually exceeding $100,000 per year. Conversely, only 2 of the 13 interviewed grantees with positive operating margins receive these funds.

Being part of a larger hospital system did not provide direct financial benefits to the majority of interviewed grantees. Of the 10 interviewed grantees that are part of a multihospital system, only 2 are subsidized by the system. The benefits that interviewed hospitals reported from multihospital systems include technical assistance, physician recruitment, and investment and purchasing discounts.

Community donations strengthen already viable grantees but do not contribute to the survival of financially weak grantees. Twenty-seven of the interviewed grantees receive less than $5,000 per year in financial contributions from their communities. Ironically, 9 of the 10 hospitals that receive more than $5,000 per year from their communities already make a profit on operations.

Despite Congress' intention for the grant program to improve the financial viability of grantees, 16 considered only community need in developing their projects. Another 16 interviewed grantees considered both community need and financial benefits when developing their grant projects. Only five interviewed grantees designed their grant projects to bolster their finances. In addition, only 15 projects generated enough revenue by the time of the interview to be self-supporting.

Nevertheless, most interviewed grantees described their grant projects as important to the long-term survival of their hospital. Many felt that their grant projects helped them respond to or prepare for changes in health care delivery. In addition, many viewed their projects as helpful in focusing them on promoting community health rather than providing only acute medical care.

GRANTEE STATUS

Among the 470 grants awarded in 1992, 1993, and 1994, 444 are still active and 26 have ended. All but 1 of the 26 inactive grantees discontinued their grants; only 1 hospital closed. (See Table 1.)

During the past 6 months, 17 grantees left the program. Ten were from the 1992 cohort, and four of these 1992 grantees left because they received new RHCT grants. Seven of the discontinued grantees were from the 1993 cohort. Six of these 1993 grantees withdrew, and one was no longer eligible.

TABLE 1

GRANTEE STATUS

	1989	1990	1991	1992	1993	1994
Months Since Award	--	--	--	21	6	0
Continuing	--	--	--	144	170	129
Completed	174	181	162	0	0	0
Discontinued Grant	6	26	22	19	7	0
Hospital Closed	4	5	3	0	1	0
Total Awards	**184**	**212**	**187**	**163**	**178**	**129**

1992 GRANTEES: PROGRESS AFTER 21 MONTHS

After 21 months, the majority of 1992 grantees remain on schedule. The most common activities are recruiting (70 percent), equipment purchases (62 percent), and staff training and development (60 percent). One-fourth or more reported completing recruitment, equipment purchases, planning or market analysis, rural health networks, construction, and clinic and swing bed implementation. Grantees frequently reported construction holdups because of contractor delays and tasks requiring more resources than expected. Some grantees overcame delays during the past 6 months. For example, grantees pursuing inpatient or hospice services, planning and marketing analyses, and outpatient services and clinics were less likely to be behind schedule after 21 months than after 15 months.

1993 GRANTEES: PROGRESS AFTER 6 MONTHS

Six months into their projects, the 1993 grantees were on schedule with most project activities. Four grantees completed all of their objectives, almost half adhered to schedule for all of their objectives, and none reported being behind schedule on all objectives. The objectives most likely to be implemented within 6 months included coordinating with other providers (17 percent) and expanding support services (17 percent). The most commonly reported delayed objectives or implementation problems involved staffing or recruitment. Thirty to 45 percent of the grantees that were expanding inpatient services or recruiting providers reported being behind schedule by more than 1 month. Similar to grantees in earlier cohorts, recruitment of providers (44 percent) and staff development and training (42 percent) were among the most popular grant project objectives.

1994 GRANTEE SOLICITATION

In 1994, 346 hospitals in 44 states applied for RHCT grants. HCFA selected grantees on the basis of merit, with an eye toward equitable geographical distribution across states. In September 1994, HCFA awarded first-year funding of $5,643,842 to 129 hospitals. The average amount awarded to the 1994 grantees for the first year of their projects was $43,751, comparable to average awards in previous years. Forty-two percent of the grantees are from the Midwest region, reflecting high application rates from this area. Twenty-four percent of 1994 grantees are in consortia, similar to proportions of earlier cohorts.

I. INTRODUCTION

In this chapter, we summarize the legislation that authorized the Rural Health Care Transition (RHCT) Grant program. We also update the number and national distribution of grantees that have ever participated in it. In Chapter II, we describe the characteristics of the 1993 grantees and compare them with the characteristics of grantees in earlier cohorts. Chapters III and IV describe the progress of the 1992 and 1993 grantees, respectively. In Chapter V, we describe the application and award process for 1994 grantees. Chapter VI presents our findings from telephone interviews with a sample of 1992 and 1993 grantees that operate in low-income counties.

A. LEGISLATIVE HISTORY AND PURPOSE OF THE GRANT PROGRAM

In 1987, Congress mandated the RHCT grants program to help small rural hospitals address changes in their environment and improve their financial and managerial strength. The legislation authorized the Health Care Financing Administration (HCFA) to:

> Establish a program of grants to assist eligible small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide in order to adjust for one or more of the following factors:
>
> (A) Changes in clinical practice patterns
>
> (B) Changes in service populations
>
> (C) Declining demand for acute-care inpatient hospital capacity

> (D) Declining ability to provide appropriate staffing for inpatient hospitals
>
> (E) Increasing demand for ambulatory and emergency services
>
> (F) Increasing demand for appropriate integration of community health services
>
> (G) The need for adequate access to emergency care and inpatient care in areas in which a number of underutilized hospital beds are being eliminated . . .
>
> Each demonstration project . . . shall demonstrate methods of strengthening the financial and managerial capability of the hospitals involved to provide necessary services.[1]

Furthermore, the legislation required the HCFA administrator to report to Congress on program progress every 6 months.[2]

The legislation also described eligibility criteria and limitations on the use of grant funds. The legislation stipulated that "a grant may not exceed $50,000 a year and may not exceed a term of two years."[3] Funds could be spent for any expense incurred in planning and implementing a project, with two exceptions: (1) no part of the grant funds could be used to retire debt incurred before the grant award; and (2) no more than one-third of the grant funds could be used to cover capital-related costs. To be eligible for a grant, a hospital had to be a non-Federal, nonprofit, short-term, general acute-care hospital with fewer than 100 beds and had to be classified as a rural hospital under Medicare's prospective payment system.[4]

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[1] Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203, Section 4005[e]).

[2] This progress report was prepared by Mathematica Policy Research, Inc., under contracts 500-91-0075 and 500-94-0011 to HCFA.

[3] Section 4005(e)(6) of the act.

In 1989, Congress modified the RHCT grants program.[5] First, the grant period for hospitals receiving an award after fiscal year 1989 was extended from 2 to 3 years. Second, the one-third capital expenditure maximum was lifted for hospitals that use their grants to convert to rural primary care hospitals (as described in Section 1820 of the Social Security Act) or to develop rural health networks (as defined in Section 1820[g] of the Social Security Act).

The amount of funds appropriated by Congress for the program has varied over the years:

Fiscal Year	Amount
1989	$8.3 million
1990	$17.8 million
1991	$24.4 million
1992	$23.0 million
1993	$22.8 million
1994	$21.1 million

The funds increased from 1989 through 1991, consistent with increases in the number of active grantees each year. Since 1991, the funding level has remained approximately the same--enough to support the three active cohorts of grantees.

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[4] Section 4005(e)(2) of the act.

[5] Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239, Section 6003[g]).

B. THE NUMBER AND DISTRIBUTION OF GRANTEES

HCFA uses two criteria to select RHCT grant recipients: (1) the equitable distribution of funds across states; and (2) reviewers' assessment of project merits. HCFA distributes the funds across states in proportion to the number of eligible hospitals. Awards are then made within each State on the basis of merit. The remaining funds are awarded on the basis of merit without regard to State. Under these criteria, 876 hospitals (45 percent of eligible rural hospitals) participated in the RHCT grants program between 1989 and 1994. The State-by-State distribution of the number and percentage of hospitals receiving RHCT grants between 1989 and 1994 is shown in Figure I.1.[6]

Because the funds are distributed equitably across states, the *number* of grantees in a State corresponds roughly to that State's portion of the eligible hospitals nationwide. As Figure I.1 shows, Texas has the largest number of hospitals awarded RHCT grants (75), followed by Minnesota and Iowa (56 and 54, respectively). (Texas ranks first, Minnesota ranks third, and Iowa ranks fourth in number of eligible hospitals.)

On the other hand, the *percentage* of eligible hospitals awarded a grant within a particular State may reflect a more organized effort to pursue grants. States with a higher percentage of grants are winning more of the remaining merit funds. The number and quality of grant applications affect the percentage of winners in each State. An analysis of the percentage of eligible hospitals ever having received a grant in each State shows that states in which more than 50 percent of the eligible hospitals participated in the grant program are generally

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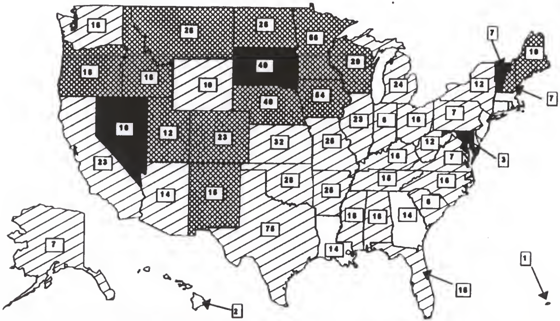
[6] In 1994, there were 1,960 eligible rural hospitals nationwide.

FIGURE I.1

NUMBER AND PERCENTAGE OF ELIGIBLE HOSPITALS AWARDED RURAL HEALTH CARE TRANSITION GRANTS BETWEEN 1989 AND 1994, BY STATE



Percentage of eligible rural hospitals awarded Rural Health Care Transition grants:

☐	None	▨	25 to 50%	■	76% or more
☐	Less than 25%	▩	51 to 75%		

NOTE: The number of hospitals with Rural Health Care Transition grants is shown on the map.
A total of 878 hospitals received Rural Health Care Transition grants between 1989 and 1994.
Connecticut, Delaware, New Jersey, and Rhode Island did not have eligible hospitals in 1994.
A 1991 grantee in Connecticut was reclassified as an urban hospital and does not appear on the map.

clustered in three areas of the country: (1) New England; (2) the Northern plains; and (3) the Mountain region. By contrast, states with the lowest program participation rates are located in the South. It is unclear why grant program participation differs among these regions.

II. CHARACTERISTICS OF GRANTEES AT AWARD, 1989 THROUGH 1993

In this chapter, we describe the characteristics of 1993 grantees and the extent to which this grantee cohort differs from the four cohorts from 1989 to 1992. The characteristics of participants in an established, ongoing program may differ from the characteristics of participants in a new and unfamiliar program. Over time, new programs may gain publicity from program success or from the word-of-mouth of participants. This program validation by early participants may convince less willing or less able participants to apply to the program. As a result, we might expect participants in the later years of a new program to have, for example, smaller staffs or more tenuous financial performance than participants in the first few years of a new program. Drawing on data reported by grantees in their first background reports, we examine for the five cohorts from 1989 to 1993 the following characteristics at the time of grant award:

- ***Management***: hospital ownership, inclusion in multihospital systems, and use of outside management companies
- ***Finances***: assets to liabilities ratio, current ratio, operating margin, overall margin, annual revenues, and special reimbursement status
- ***Staffing Levels***: current staffing levels (including physicians, nurses, midlevel staff, and other staff) and current staff vacancies
- ***Service Area***: number of competitors, fraction of patients in the service area using the grantee hospital, travel time to other hospitals, and frequency of problems in accessing other services

- ***Services Provided***: size of hospital, occupancy rate, whether the hospital delivers babies and the availability of emergency room, general surgical specialties, swing beds, and routine medical transportation

- ***Plans for Change:*** consideration of conversion, consolidation, or closure

In general, the 1993 cohort resembles the earlier cohorts. The many small differences among cohorts generally reflect year-to-year variation we expect in the grant program. Nevertheless, some measures changed more substantially over time, suggesting evidence of general trends. Some of the notable trends emerging with each new grantee cohort include larger proportions of grantees qualifying for special reimbursement status, employing physician assistants, recruiting physicians, and having swing beds. The changes we discuss involved differences of eight percentage points or more in the fraction of a cohort with a specific characteristic, as well as a pattern across cohorts suggesting consistent change.

A. MANAGEMENT CHARACTERISTICS

Almost all of the 1993 grantees were owned by a county or hospital district (which is created under government authority and usually has taxing authority) or operated as private, nonprofit organizations. In addition, a minority operated within multihospital systems or were under contract management. (See Table II.1.) Almost half (45 percent) were owned by a county or district, and a slightly smaller proportion (42 percent) were private, nonprofit facilities. A city or other public entity owned the remaining 13 percent. For the most part, the hospitals functioned independently, although 17 percent belonged to a multihospital system and 31 percent contracted with outside management companies.

TABLE II.1

DISTRIBUTION BY MANAGEMENT CHARACTERISTICS AT TIME OF AWARD (1989 THROUGH 1993 GRANTEES)

	Percent Distribution				
Characteristic	1989	1990	1991	1992	1993
Ownership					
City	9	9	8	5	10
County/district	40	44	47	46	45
Other public	2	1	1	1	3
Private, nonprofit	49	46	44	48	42
Multihospital System	23	17	20	14	17
Nonprofit	22	14	19	12	17
For profit	1	2	1	2	0
Outside Management Contract	28	28	27	22	31
Nonprofit	15	17	14	8	18
For profit	13	12	13	14	13
Total	**175**	**205**	**182**	**155**	**170**

SOURCE: Self-reported monitoring and background forms.

NOTE: For-profit hospitals were not eligible for grants, but nonprofit hospitals that were managed by for-profit organizations or hospital systems were eligible.

The management characteristics of 1993 grantees were similar to those of earlier grantee cohorts. Across all five cohorts, most of the grantees were either owned by a county or health district or were private, nonprofit facilities. The use of outside support--participation in outside management contracts or multihospital systems (often to gain access to management contracts)--has also been relatively constant, although the 1992 cohort was less likely than the others to use either type of support.

B. GRANTEE FINANCES

Net patient revenue estimates reflect grantees' relatively small size. Hospitals in the 1993 cohort averaged $6.4 million in annual net patient revenue, while the corresponding figure for all hospitals nationwide averaged more than $45 million per year (American Hospital Association 1993, Table 11).

We used four measures to summarize the financial condition of the grantees: two measures describe their balance sheets, and two summarize their net income flow. We used the ratio of total assets to total liabilities to measure the net worth of a hospital. This ratio indicates the underlying net value of the hospital as a business. The current ratio, current assets divided by current liabilities, indicates the working capital position of the hospital.[1] While there are no absolute standards for the current ratio, firms with a ratio greater than 1.5 are generally thought to have a strong current position. Nationwide, the ratio of total assets to total liabilities for small rural hospitals averages 4.8, while the current ratio averages 2.9.

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[1] Current assets include cash, marketable securities, accounts receivables, and other assets that can be converted into cash in the short term. Current liabilities include accounts payable, accrued payroll, accrued taxes, and other similar short-term liabilities.

We used measures of operating margin and overall margin to summarize the grantees' income flow. The operating margin looks at the net income from patient services and indicates whether a hospital generates a surplus or loss on its basic business. The overall margin looks at all income and expense flows for the hospital and indicates whether any operating losses are offset by nonoperating income, such as contributions from local government or charities.

On average, hospitals in the 1993 cohort had favorable balance sheets but unfavorable income flow. (See Table II.2.) Assets generally outweighed liabilities in the long and short term. On average, 1993 grantees reported twice as many total assets as total liabilities and current ratios of over 2. Nevertheless, many 1993 grantees lost money on operations, as evidenced by negative operating margins. In the year before receiving the grant, over half of the 1993 grantees reported losses of 2 percent or more of net patient revenue; altogether, 67 percent reported negative operating margins. Grantees usually offset this shortfall in operations with nonoperating revenues. For example, the 1993 grantees reported a median overall margin of 2 percent, and 58 percent of the 1993 grantees had positive overall net incomes.

However, this overall picture of grantee finances masks important variation within the cohort. In particular, 22 percent of the 1993 grantees were experiencing serious financial problems in that they lost money on operations and had a current ratio below 1.5. The unfavorable income flow was particularly acute for the smallest grantees (those with fewer

TABLE II.2

FINANCIAL CHARACTERISTICS AT TIME OF AWARD (1989 THROUGH 1993 GRANTEES)

Characteristic	1989	1990	1991	1992	1993
Net Patient Revenue (Mean Unadjusted Dollars)	4,943,903	4,857,432	5,064,761	5,912,936	6,448,119
Ratio of Total Assets to Total Liabilities (Median)	2.12	2.25	3.27	2.75	2.20
Current Ratio (Ratio of Current Assets to Current Liabilities) (Median)	2.01	2.27	2.27	2.35	2.20
Operating Margin (Median)[a]	-0.04	-0.04	-0.04	-0.01	-0.02
Overall Margin (Median)[b]	0.10	0.06	0.01	0.04	0.02
Percent Distribution of Grantees with Special Reimbursement Status					
Sole community hospital	21	29	39	52	47
Disproportionate share hospital	9[c]	14	19	30	28
Total	**166**	**183**	**173**	**155**	**165**

SOURCE: Self-reported background information for the year prior to grant award. ***Preliminary data for 1992 and 1993 may change after cleaning.***

NOTE: Some hospitals did not report all data elements. Figures represent hospitals reporting the data element.

[a] Defined as $\frac{\text{Net Patient Revenue - Total Operating Expenses.}}{\text{Net Patient Revenue}}$

[b] Defined as $\frac{\text{Total Net Operating Revenue + Nonoperating Revenue -Total Expenses}}{\text{Total Net Operating Revenue + Nonoperating Revenue}}$

[c] Wording of the question for this cohort differed slightly from later cohorts and may account for some of the difference between 1989 and later cohorts.

than 32 licensed acute-care beds). These grantees had the worst median operating margin (-0.07) and overall margin (0.01). Medium-sized grantees (those with between 32 and 60 licensed acute-care beds) had better margins (-0.02 and 0.02, respectively). The largest grantees (those with between 61 and 100 licensed acute-care beds) typically made money on operations and had the best median operating margin (0.05) and overall margin (0.05).

Many grantees in the 1993 cohort also qualified for special reimbursement status under the Medicare and Medicaid programs. Almost half (47 percent) qualified as sole community hospitals because they are the sole source of inpatient care for a geographic area, because of severe weather or travel conditions or the absence of other hospitals within 35 miles of the grantee (U.S. House of Representatives 1994). In addition, 28 percent of the 1993 grantees qualified as disproportionate share hospitals because they serve a disproportionate share of low-income patients, relative to other hospitals in the country. Medicare provides higher reimbursements for inpatient services delivered by hospitals with either of these special designations, in order to ensure beneficiaries' access to services and to improve the financial viability of these facilities. The Medicaid program also provides additional payments to disproportionate share hospitals.

The financial condition of grantees in the five cohorts was similar, but the fraction of grantees with special reimbursement status has clearly increased. In 1989, only 21 percent qualified as sole community hospitals, and 9 percent qualified as disproportionate share hospitals. These proportions increased each year, to a high of 52 percent and 30 percent, respectively, in 1992. The proportions of 1993 grantees were almost as high (47 percent and

28 percent, respectively). The nationwide increase in hospitals that qualified for disproportionate share status partly accounts for the change between cohorts. In 1989, approximately one-fifth of hospitals nationwide qualified for this status; in 1994, approximately one-third qualified for this status (Prospective Payment Assessment Commission 1989 and 1994).

C. STAFFING

As with net patient revenue, staffing patterns also reflect the small size of grantees. Hospitals in the 1993 cohort averaged 24 full-time-equivalent (FTE) registered nurses, 15 percent of the national average of 162 (American Hospital Association 1993, Table 6). These relatively small staffs make operations sensitive to any change in staffing. On average, 1993 grantees had 9 physicians on staff and employed 10 FTE licensed practical nurses (LPNs), as well as 12 FTE aides and orderlies. (See Table II.3.) Furthermore, a substantial proportion had very few staff members; approximately one-third had fewer than 3 physicians on staff, and one-third employed fewer than 10 registered nurses.

Grantee cohorts between 1989 and 1992 had approximately the same staffing levels as 1993 grantees, except for physician assistants. Grantees in 1991, 1992, and 1993 were more likely to employ physician assistants than grantees in 1989 or 1990. In 1989, only six percent employed physician assistants. Larger proportions of subsequent cohorts reported employing physician assistants; by 1993, 19 percent--three times as many grantees as in 1989--reported employing physician assistants.

TABLE II.3

STAFFING AT TIME OF AWARD (1989 THROUGH 1993 GRANTEES)

	Percent Distribution or Mean Number of Grantees				
	1989	1990	1991	1992	1993
Number of Physicians on Staff					
1 to 3	28	27	35	28	31
4 to 10	39	46	40	44	41
11 to 25	25	18	19	20	20
26 or more	8	9	7	8	8
Mean number of physicians on staff	10	10	9	9	9
Number of Registered Nurses (FTEs)					
Zero	7	2	5	2	2
1 to 10	38	33	36	39	37
11 to 20	15	28	29	24	25
21 to 50	28	28	21	20	23
51 or more	13	9	11	15	14
Mean number of registered nurses (FTEs)	23	22	21	23	24
Number of LPNs (FTEs)					
Zero	3	3	7	6	5
1 to 5	27	30	35	40	37
6 to 10	32	27	26	24	24
11 to 20	20	24	18	21	19
More than 20	19	15	14	10	15
Mean number of LPNs (FTEs)	12	11	10	9	10
Number of Aides and Orderlies (FTEs)					
Zero	12	6	9	8	6
1 to 5	23	27	27	22	27
6 to 10	20	21	32	25	28
11 to 20	25	28	16	27	19
More than 20	21	20	16	18	20
Mean number of aides and orderlies (FTEs)	13	13	10	12	12
Number of Physician Assistants (FTEs)					
Zero	94	86	81	82	81
1 to 2	5	13	16	14	16
3 or more	1	1	3	4	3
Mean number of physician assistants (FTEs)	0	0	0	0	0
Number of Nurse Practitioners (FTEs)[a]					
Zero	45	53	52	49	45
1 to 2	47	42	41	43	44
3 or more	7	5	7	9	11
Mean number of nurse practitioners (FTEs)	1	1	1	1	1
Total	**174**	**205**	**182**	**159**	**167**

SOURCE: Self-reported background information.

NOTE: Some hospitals did not report all data elements. Figures represent hospitals reporting the data element.

[a] Includes nurse practitioners and nurse anesthetists.

FTE = Full-time-equivalent.

The nationwide increase in Rural Health Clinics partially accounts for the change in grantees' use of physician assistants. Congress passed the Rural Health Clinic Services Act (P.L. 95-210) in 1977 and subsequent amendments to increase access to care and to encourage utilization of midlevel practitioners by reimbursing their services through Medicare and Medicaid even in the absence of a full-time physician. Rural Health Clinics must operate in rural, health professional shortage areas, medically underserved areas, or Governor-designated shortage areas; employ at least one midlevel practitioner; and offer a specified set of minimum services (Travers and Ellis 1992). In turn, they receive cost-based reimbursement from Medicare and Medicaid under this special provider designation. While some Rural Health Clinics are owned by hospitals, even the proliferation of independently-operated Rural Health Clinics may have familiarized hospitals with the abilities of physician assistants and thus, led more hospitals to employ these providers. In 1990, when amendments encouraging the development of Rural Health Clinics were passed, 551 Rural Health Clinics operated. By January of 1995, the number of Rural Health Clinics almost quadrupled, to 2,057 (Health Care Financing Administration OSCAR database, 1995).

Although almost all 1993 grantees reported physician vacancies, much smaller proportions reported vacancies for nurses and other clinical staff. (See Table II.4.) All but one grantee reported trying to hire physicians at the time of grant award. In addition, one-quarter reported seeking five or more physicians. On the other hand, smaller proportions reported seeking other clinical staff. Only 50 percent reported registered nurse vacancies, 25 percent reported LPN vacancies, and 30 percent reported vacancies for aides and orderlies. Most of

TABLE II.4

STAFF VACANCIES AT TIME OF AWARD
(1989 THROUGH 1993 GRANTEES)

	Percent Distribution or Mean Number of Grantees				
	1989	1990	1991	1992	1993
No Physician Vacancies	44	23	14	18	1
Physician Vacancies	56	77	86	82	99
Recruiting 1 to 2	42	34	45	44	49
Recruiting 3 to 4	11	20	21	16	25
Recruiting 5 or more	4	22	20	23	25
Mean number of physician vacancies	1	3	3	3	3
No Registered Nurse Vacancies	21	29	36	33	52
Registered Nurse Vacancies (FTEs)	79	71	64	67	48
1 to 2	34	30	38	35	26
3 to 9	40	38	24	31	21
10 or more	5	4	2	1	1
Mean number of Vacancies	3	3	2	2	2
No LPN Vacancies	57	63	69	69	76
LPN Vacancies (FTEs)	43	37	31	31	24
One	16	11	14	17	13
More than one	27	26	16	14	11
Mean number of vacancies	1	1	1	1	1
No Aide and Orderly Vacancies	63	71	76	75	70
Aide and Orderly Vacancies (FTEs)	37	29	24	25	30
One	11	8	12	10	8
More than one	26	21	12	15	22
Mean number of Vacancies	1	1	1	1	1
No Physician Assistant Vacancies	92	90	90	90	85
Physician Assistant Vacancies (FTEs)	8	10	10	10	15
One	6	9	8	9	12
More than one	2	1	2	1	3
Mean number of vacancies	0	0	0	0	0
No Nurse Practitioner Vacancies[a]	86	87	89	90	84
Nurse Practitioner Vacancies (FTEs)	14	14	11	11	16
One	12	10	9	9	13
More than one	2	4	2	2	4
Mean number of vacancies	0	0	0	0	0
Total	**174**	**205**	**182**	**159**	**167**

SOURCE: Self-reported background information.

NOTE: Some hospitals did not report all data elements. Figures represent hospitals reporting the data element.

[a] Includes nurse practitioners and nurse anesthetists.

FTE = Full-time-equivalent.

the grantees with vacancies for nurses, aides, and orderlies reported seeking only one or two more FTEs. Only about 15 percent reported vacancies for physician assistants or nurse practitioners, and these grantees generally reported seeking only one FTE for these positions.

While larger proportions of grantees in 1991, 1992, and 1993 than in earlier years reported physician vacancies, smaller proportions in 1991, 1992, and 1993 reported vacancies for registered nurses and LPNs. In 1989, only 56 percent reported physician vacancies. In each subsequent year, larger proportions of grantees reported physician vacancies, until 1993, when all but one grantee reported physician vacancies. In contrast, 79 percent of 1989 grantees reported registered nurse vacancies; smaller proportions of subsequent cohorts reported seeking nurses until 1993, when only 48 percent of grantees reported doing so. The same pattern appeared with the proportion of grantees seeking LPNs; 43 percent of 1989 grantees reported seeking LPNs; by 1993, only 24 percent reported doing so.

D. SERVICE AREA CHARACTERISTICS

Grantees are important health care providers in their communities and are sometimes the only ones. The majority of 1993 grantees reported being the only acute-care hospitals in their service areas. (See Table II.5.) In addition, large proportions of the communities use the grantee hospitals; 80 percent of 1993 grantees reported that more than half of the patients in their service areas went to the grantee hospital for care. Part of the reason for the high proportion of community use may be isolation. For the typical 1993 grantee, the nearest acute-care hospital was 45 minutes away, and tertiary and urban hospitals were even farther away (80 and 90 minutes, respectively).

TABLE II.5

SERVICE AREA CHARACTERISTICS AT TIME OF AWARD (1989 THROUGH 1993 GRANTEES)

	Median or Distribution				
Characteristic	1989	1990	1991	1992	1993
Percentage of Grantees Reporting Being the Only Acute-Care Hospitals in Service Area	67[a]	62	62	61	65
Percentage of Patients in Service Area that Use Grantee Hospital for Services					
50 percent or more	73	82	77	82	80
Less than 50 percent	27	18	23	18	20
Travel Time in Minutes from Grantee to:[b]					
Nearest acute-care hospital	40	35	35	45	45
Nearest tertiary-care hospital	67	75	75	90	80
Nearest urban hospital	75	80	75	90	90
Number of Primary Care Facilities in Service Area					
Rural health clinics	0	0	0	0	1
Public health clinics	1	1	1	0	1
Community health centers	0	0	0	0	0
Migrant health centers	0	0	0	0	0
Percentage of Grantees Reporting at Least One Rural Health Clinic, Public Health Clinic, Community Health Center, or Migrant Health Center in Service Area	76	73	70	67	76
Number of Nursing Homes in Service Area	2	2	2	2	2
Percentage of Grantees with Problems Accessing Nursing Home Beds (Always or Often)	30	25	23	23	25
Number of Home Health Agencies in Service Area	1	2	1	1	2
Percentage of Grantees with Problems Accessing Home Health Services					
Skilled care services	22	25	23	20	21
Personal care/homemaker services	40	32	36	26	29
Total	**174**	**205**	**183**	**160**	**169**

SOURCE: Self-reported background information.

NOTE: Some hospitals did not report all data elements. Percentages represent hospitals reporting the data element.

[a] The question wording in 1989 differed slightly from that in other years and may account for some of the difference between 1989 and later years.

[b] Travel time by automobile. Two hospitals in 1989 data and one hospital in 1993 data that are located on islands were not included.

While the availability of primary care appeared adequate in the service area of 1993 grantees, some grantees reported problems accessing posthospital services. In addition to primary care physicians, approximately 76 percent of 1993 grantees reported having at least one of the following primary care providers in their service areas: Rural Health Clinics, public health clinics, migrant health clinics, or community health centers. Although 1993 grantees typically reported two nursing homes and two home health agencies in the service area, 7 percent reported no nursing homes and 12 percent reported no home health agencies for their patients. Approximately 20 to 30 percent of 1993 grantees reported problems accessing these services. In addition, 25 percent of 1993 grantees reported always or often experiencing problems with access to nursing home beds, 20 percent reported problems with access to skilled home health care services, and 29 percent reported problems with access to personal care or homemaker services.

The service areas of 1993 grantees were generally similar to those of earlier cohorts, except for (1) travel time by automobile to bigger hospitals and (2) access to personal care or homemaker services. The difference in travel time is seen in 1992 and 1993 grantees being more isolated than their counterparts in earlier cohorts from tertiary or urban hospitals. Grantees in earlier cohorts were 67 or 75 minutes away, on average, from the nearest tertiary hospital; grantees in 1992 and 1993 were 80 or 90 minutes away, on average. Similarly, grantees in earlier cohorts were 75 or 80 minutes away, on average, from urban hospitals, and grantees in 1992 and 1993 were 90 minutes away, on average. In addition, 1993 grantees were 25 percent more likely than 1989 grantees to be more than 2 hours from a tertiary care hospital and 38 percent more likely than 1989 grantees to be more than 2 hours from an urban hospital (not shown). The difference in access to personal care or homemaker services is seen in 1993 grantees being less likely than grantees in 1989 to report problems with access to home health agencies providing personal care or homemaker services. In 1989, 40 percent of grantees reported these types of problems. The proportion reporting such problems subsequently decreased, with some fluctuation, to 29 percent in 1993.

E. HOSPITAL SERVICES

The statistics describing the 1993 grantees' service characteristics indicate that grantee hospitals were quite small in comparison to hospitals nationwide. Grantees in 1993 typically staffed 30 acute-care beds; nationwide, hospitals typically staffed 110 acute-care beds (Health Care Investment Analysts, Inc., and Deloitte & Touche 1993). (See Table II.6.) In fact, 36 percent of the 1993 grantees staffed fewer than 25 acute-care beds, and only 21 percent staffed more than 50 acute-care beds.

In addition, grantees had low occupancy rates compared with hospitals nationwide. Less than one-third of grantee hospitals reported occupancy rates in excess of 50 percent; one-third reported occupancy rates below 25 percent. Grantees in 1993 had median occupancy rates of 36 percent; nationwide, hospitals had median occupancy rates of 48 percent (Health Care Investment Analysts, Inc., and Deloitte and Touche 1993). The low occupancy rates of grantees partly are due to the Hill-Burton Act (P.L. 79-725) in 1946 and later amendments, which encouraged many rural communities to build their own small hospitals, despite a much higher bed to population ratio in these rural communities than in some urban areas (U.S. Congress, Office of Technology Assessment 1990, p. 119). In addition, the Office

TABLE II.6

SERVICES PROVIDED AT AWARD
(1989 THROUGH 1993 GRANTEES)

Characteristic	Percentage of Grantees				
	1989	1990	1991	1992	1993
Number of Staffed Hospital Beds[a]					
1 to 25	34	32	37	37	36
26 to 50	45	47	44	43	43
51 to 75	11	14	16	11	15
76 or more	10	7	4	8	7
Median number of staffed beds	35	34	29	32	30
Occupancy Rate for Staffed Beds[a]					
10 percent or less	8	2	4	3	5
11 to 25 percent	18	17	20	15	27
26 to 40 percent	28	28	26	31	24
41 to 50 percent	20	20	12	21	16
51 to 75 percent	20	24	25	23	25
More than 75 percent	8	9	12	7	4
Median occupancy rate	38	42	40	42	36
Deliver Babies	•	69	69	72	69
Provide General Surgical Specialty Services	•	84	83	85	82
Emergency Room Available	100	100	100	100	100
Swing Beds Available	66	69	72	74	77
Routine Medical Transportation System Available	48	68[b]	66	68	62
Without restrictions	13	14	21	22	20
With restrictions	35	54	45	46	42
Total	**173**	**205**	**182**	**155**	**170**

SOURCE: Self-reported background information.

NOTE: Some hospitals did not report all data elements. Percentages represent hospitals reporting the data element.

• The first background form for 1989 grantees did not collect this information.

[a] These figures may be overstated by some grantees that included skilled nursing beds.

[b] A change in question wording between 1989 and 1990 partially accounts for the difference between 1989 and 1990.

of Technology Assessment (1990) reported a general correlation between small numbers of hospital beds and low occupancy rates.

The 1993 grantees varied in the basic services they offered. Eighty-two percent of 1993 grantees provided inpatient general surgery specialty services, and 69 percent delivered babies. All of the 1993 grantees had an emergency room, and three-quarters had swing beds. About 20 percent were served by a routine medical transportation system available to the general public.

Grantees in 1993 were far more likely to have swing beds than grantees in earlier cohorts. Greater proportions had swing beds available in each successive year between 1989 and 1993. The Omnibus Budget Reconciliation Act of 1980 and later amendments established the Medicare swing bed program to address the shortage of skilled nursing home beds and the low occupancy rates of small, rural hospitals. After meeting State and Federal requirements for skilled nursing facilities, rural hospitals with fewer than 100 acute-care beds can designate a portion of their beds to serve as both acute-care and skilled nursing beds, and bill Medicare accordingly (Prospective Payment Assessment Commission 1993). In 1989, 66 percent of grantees offered swing beds. By 1993, that proportion had increased to 77 percent, an increase of 17 percent over 4 years.

Median occupancy rates have fluctuated over time. Grantees in 1993 had the lowest occupancy rate of the five cohorts (36 percent), but this rate was similar to that for grantees in 1989 (38 percent). Grantees from 1990 through 1992 had occupancy rates between 40 percent and 42 percent. The 1993 grantees' low median occupancy rate was partially a result of the large proportion (32 percent) reporting occupancy rates of less than 25 percent; at most, 26 percent of grantees in each cohort reported occupancy rates this low.

The other service characteristics of 1993 grantees did not differ markedly from those of grantees in earlier cohorts. For example, across the five cohorts, approximately 70 percent of grantees delivered babies, slightly more than 80 percent provided general surgical specialty services, and all had emergency rooms. Approximately two-thirds of grantees in four of the five cohorts had routine medical transportation available.

F. POTENTIAL FOR CONVERSION, CONSOLIDATION, OR CLOSURE

In the past 3 years, a small proportion of 1993 grantees considered the more dramatic forms of adapting to the changing health care environment, that is, conversion to another type of health care facility, consolidation with another hospital, or closure. Approximately 14 percent considered conversion to another type of health care facility, such as a nursing home or specialty clinic center. (See Table II.7.) A smaller proportion, approximately eight percent, considered consolidation with another acute-care hospital. Consolidation with another hospital could also result in the smaller hospital converting to another type of health facility, such as a nursing home or clinic. Approximately 16 percent of 1993 grantees considered closing the hospital completely.

The proportions of grantees that considered conversion, consolidation, or closure between 1989 and 1993 were similar. Slightly higher proportions of grantees in 1989 than in 1993 reported considering conversion (17 percent) or consolidation (14 percent), but the proportions were still small.

TABLE II.7

CONSIDERATION OF CONVERSION, CONSOLIDATION, OR CLOSURE: 1989 AND 1993 GRANTEES

Percentage of Hospitals that Have Considered:	1989	1993
Conversion to an Alternative Type of Health Care Facility	17	14
Consolidation with One or More Acute-Care Hospitals	14	8
Closure	15	16
Total	**175**	**169**

SOURCE: Self-reported background information.

NOTE: Includes hospitals that closed and hospitals that reported considering each alternative seriously or moderately. Some hospitals did not report all data elements. Percentages represent hospitals reporting the data element.

III. SELF-REPORTED PROGRESS OF 1992 GRANTEES

The fourth progress report from 1992 grantees--covering January 1, 1994 through June 30, 1994--was due on August 5, 1994. This chapter looks at the 143 grantees who returned their progress reports in time to be included in this report.

A. STATUS OF 1992 GRANTEES

During the 6 months covered by this report, 10 grantees voluntarily left the grant program. Of these, four were awarded new Rural Health Care Transition (RHCT) grants and opted to discontinue their 1992 grants. One hundred and forty-four of the original 163 grantee hospitals (88 percent) were still participating in the grant program after 21 months. (See Table III.1.)

B. PROGRESS OF 1992 GRANTEES

The 1992 grantees continued to make steady progress during the past 6 months. Sixty-three percent were on schedule after 21 months, and four percent completed all planned project activities. (See Table III.2.) Although 33 percent were more than a month behind on at least one activity, their overall status after 21 months was very similar to that of the 1991 grantees after 21 months. Thirty-five percent of the 1991 grantees were behind schedule on at least one project activity last year at this time (Cheh and Giggie 1994).

The 1992 grantees' most frequent grant project activities continued to be recruitment (96 grantees), equipment purchases (86 grantees), and training and staff development

TABLE III.1

1992 GRANTEE STATUS

	At Award 9/15/92	Month 3 1/1/93	Month 9 7/1/93	Month 15 1/1/94	Month 21 7/1/94	Cumulative 9/15/92 to 7/1/94
Number of Grantees at Start of Period	163	163	161	154	154	163
Number of Discontinuations in Period	0	2 [b]	7 [c]	0	10 [f]	19
Number Remaining at End of Period	163	161	154	154	144	144
Number that Made Other Changes						
Ceased hospital operations but still a grantee	2 [a]	0	1 [d]	0	0	3
Changed scope	0	0	0	1 [e]	1 [g]	2

[a] Sea Level Hospital, North Carolina
Dahl Memorial Healthcare Association, Montana

[b] Alfalfa County Hospital, Oklahoma
Estelline Community Hospital, South Dakota

[c] Franklin County Medical Center, Idaho
Dimmit County Hospital, Texas
Melissa Memorial Hospital, Colorado
Sedgwick County Memorial Hospital, Colorado
St. John's Lutheran Hospital, Montana
Wedowee Hospital, Alabama
Fostoria Community Hospital, Ohio

[d] Roosevelt Memorial Medical Center, Montana

[e] Lake City Hospital, Minnesota

[f] Johnson County Memorial Hospital, Wyoming
Edwards County Hospital, Kansas
Mayo Regional Hospital, Maine
Cook County North Shore Hospital, Minnesota
Gordon Memorial Hospital, Nebraska
Chadson Community Hospital, Nebraska
Battle Mountain General Hospital, Nevada
Bennett County Hospital, South Dakota
Belle Fourche Health Care Center, South Dakota
Hamilton County Memorial Hospital, Florida

[g] Madison Valley Hospital, Montana

TABLE III.2

PROJECT PROGRESS AFTER 21 MONTHS, BY OBJECTIVE: 1992 GRANTEES

Project Objective	Total Number	Percentage Completed	Percentage Ahead of Schedule	Percentage on Schedule	Percentage Behind by More than 1 Month
Recruiting	96	33	1	48	18
Equipment Purchase	86	42	1	47	9
Training or Staff Development	83	8	0	87	5
Education, Prevention, or Wellness Programs	70	3	0	96	1
Planning or Market Analysis	56	25	2	70	4
Rural Health Network[a]	52	25	0	62	14
Outpatient Service	43	5	2	91	2
Construction or Renovation	36	42	0	39	19
Clinic	31	26	3	61	10
Management Improvements	29	7	0	69	24
Inpatient or Hospice Service	17	0	0	88	12
Other Health Service	14	7	0	79	14
Emergency Medical Services	6	0	0	100	0
Swing Beds	2	50	0	50	0
Other	32	3	0	72	25
Total	**138** [b]	**4**	**0**	**63**	**33**

SOURCE: Fourth Grantee Monitoring Report, 1992 grantees.

NOTES: Percentages may not total 100 percent because of rounding error. Only grantees that were still active at the end of 21 months are included. Progress is defined by the project's most delayed activity. For example, a project that is on schedule in only one activity and ahead of schedule in all the rest is defined to be on schedule.

[a] These rural health networks include hospital consortia, as well as formal and informal networks.

[b] Five grantees did not report timeliness.

(83 grantees). Other frequent activities included education, prevention, or wellness programs (70 grantees), as well as planning or market analyses (56 grantees). (See Table III.2.)

The 1992 grantees had more success with completing equipment purchases and renovations. Not only were the 1992 grantees more likely to complete these activities, but they also completed a larger number of these activities than the 1991 grantees at the same point in their grant projects. Forty-two percent of the 1992 grantees that were planning equipment purchases had completed them after 21 months, but only 22 percent of the 1991 grantees had done so. Similarly, 42 percent of 1992 hospitals that planned construction or renovation had completed the activity after 21 months, compared with 32 percent of the 1991 grantees (Cheh and Giggie 1994).

Incomplete construction and renovation were very likely to be more than a month behind schedule (19 percent). The reasons for falling behind varied. Some hospitals found that renovations were simply more time-consuming or costly than expected; one project was behind because of contractor delays. Another hospital encountered significant problems discussed later in this chapter. (See Section C.)

Many projects appeared to overcome delays in the past 6 months. For example, grantees that implemented inpatient or hospice services were the most likely to experience delays (24 percent) after 15 months (Bergeron et al. 1994). However, only 12 percent of the grantees implementing these projects were behind schedule after 21 months. Planning or marketing analyses, outpatient services, and clinics were also much less likely to be behind schedule after 21 months than after 15 months.

Grantees pursuing management improvement projects were among the most likely to be behind schedule by more than a month. All the grantees pursuing these projects are members of the same consortium. The consortium has had some success in improving its management system, but it has experienced delays because of resistance to establishing quality-of-care benchmarks, which will apply to all consortium hospitals.

C. PROJECT MODIFICATIONS AND PROBLEMS

Although some grantees changed the schedule or priority of their grant project components, almost all have adhered to their original plan of work. One hospital, however, abandoned its original plan. Its primary goal was to establish a home health agency, but another agency in the county received a certificate of need for the agency and began operations before the grantee had done so. Because the grantee could no longer receive a certificate of need for a home health agency, it decided to begin a hospice program and made plans to recruit a physical therapist.

Although most projects did not encounter major problems in the past 6 months, two came to a standstill. The first grantee planned to combine the resources of two limited-service hospitals to form one new hospital. While planning the consolidation, new members of city government were elected. These new political leaders strongly opposed the merger and challenged it in court. The grantee has delayed by 3 to 5 years the acquisition of the real estate needed for the new hospital.

Another hospital suffered severe management problems that caused its grant project to come to a standstill. As a result of mismanagement and neglect, this grantee had little to show after 2 years in the RHCT program for the grant money that was spent. Physical therapy services contracted for early in the grant program were discontinued, and the van purchased for a network with local service agencies was sequestered by the bankruptcy trustee representing the previous hospital management company. However, new management took over during the past 6 months and began to put the hospital back on track. The new administration began pursuing the original goal of developing a home health agency. Despite significant delays, this grantee appears to have begun the process of overcoming its difficulties.

D. GRANT EXPENDITURES

The Health Care Financing Administration (HCFA) awarded a total of $13,469,240 to the 1992 grantees in the first 2 years--$6,855,659 for the first year and $6,613,581 for the second. Twenty-one months after HCFA made the awards, the reporting hospitals had spent $11,233,755.[1]

The grantees reported spending more of their grants (44 percent) on salary and fringe benefits than on any other category, a pattern of expenses similar to that of prior grantees. Cumulative expenditures by category included:

- Salary and fringe benefits: $4,966,799 (44 percent)
- Equipment and capital: $1,630,712 (15 percent)
- Nonphysician contracts: $1,443,551 (13 percent)
- Physician contracts: $940,616 (8 percent)

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[1] This figure and other grant expenditure figures in this chapter include all amounts reported by 1992 grantees since the beginning of the program.

- Supplies: $475,362 (4 percent)
- Travel: $491,899 (4 percent)
- Other: $1,284,816 (11 percent)[2]

The 1992 grantees purchased capital items, including typewriters, fax machines, computer equipment, a treadmill, a body fat analyzer, and a van. Grantees also used grant funds to contract for many types of services, including legal and accounting assistance, lab consulting, and mammography.

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[2] Percentages do not total 100 percent because of rounding error.

IV. SELF-REPORTED PROGRESS OF 1993 GRANTEES

This chapter summarizes the 1993 grantees' progress during the first 6 months of their grants. Specifically, it draws on grantee-reported data collected in the first monitoring form, covering the period October 1, 1993 through March 31, 1994. In the following sections, we examine grantees' status in the program, progress in accomplishing project objectives, project modifications, and expenditures.

A. STATUS OF 1993 GRANTEES

The Health Care Financing Administration (HCFA) awarded Rural Health Care Transition (RHCT) grants to 178 hospitals in October 1993. After the awards, seven hospitals discontinued their grants (six withdrew from the program and one was no longer eligible). One month after award, another hospital closed before spending any of its grant funds. By the end of the sixth month, 170 grantees remained active in the program, and 4 had modified their grant projects, as discussed in Section C. (See Table IV.1.) Of the 170 active grantees, 168 returned their first progress forms. The remainder of this chapter reports the progress of these 168 grantees.

B. GRANTEE OBJECTIVES

Recruitment of providers and staff development or training were popular objectives for 1993 grantees, which were similar to earlier cohorts in this respect. Approximately 44 percent (74 grantees) of 1993 grantees reported pursuing recruitment of providers; slightly fewer (71

TABLE IV.1

1993 GRANTEE STATUS

	Since Grant Award (10/1/93 to 3/31/94)	Most Recent Reporting Period (10/1/93-3/31/94)
Status at Beginning of Period		
Active		
Retained original scope	178 [a]	178
Modified scope	0	0
Total	178	178
Discontinued Grant	0	0
Changes During the Period		
Discontinued Grant	7 [b]	7
Hospital Closed	1 [c]	1
Modified Scope	4 [d]	4
Status at End of Period		
Active		
Retained original scope	166	166
Modified scope	4	4
Total	170	170
Discontinued Grant	8	8

[a] A total of 179 grant applications was approved. However, Orange City Hospital (4342) in Iowa did not receive grant funding, will not be monitored, and will not appear in the table numbers.

[b] Baptist Memorial Hospital, Eastern Ozarks, Arkansas
Baptist Memorial Hospital, Osceola, Arkansas
Baptist Memorial Hospital, Booneville, Mississippi
Baptist Memorial Hospital, Union County, Mississippi
Baptist Memorial Hospital, Huntingdon, Tennessee
Oconto Memorial Hospital, Wisconsin
Kettering Mohican Area Medical Center, Ohio

[c] St. Joseph's Hospital and Nursing Home of Del Norte, Colorado

[d] Southern Hills General Hospital, South Dakota
Sturgis Community Health Care Center, South Dakota
Marshall County Hospital, Kentucky
Divine Savior Hospital, Wisconsin

grantees) reported pursuing staff development or training. For earlier grantees, recruiting was consistently their first or second most frequently reported objective; staff development was the third or fourth most frequently reported objective (Cheh et al. 1991b; Giggie et al. 1993; and Cheh and Giggie 1994). However, the 1993 grantees' most frequently reported objectives, pursuing expanded outpatient services and coordinating with other providers, differed from those of earlier grantees. Two-thirds (113) of the 1993 grantees planned to expand outpatient services as part of their grant. Half (85) planned to coordinate services with other providers. Only 30 to 40 percent of the grantees in most of the earlier cohorts reported pursuing each of these objectives (Cheh et al. 1991b; Giggie et al. 1993; and Cheh and Giggie 1994).

The 1993 grantees' goals of implementing outpatient services reflects a national trend. The Medicare Prospective Payment System, implemented in the 1980s, sets fixed payments from Medicare for inpatient services. In response, hospitals nationwide have diversified into outpatient services to bolster their finances. The most frequently pursued outpatient services for the 1993 grantees include: Rural Health Clinics (50 grantees); geriatric services (24 grantees); physical, occupational, respiratory, or speech therapy (21 grantees); cardiac or pulmonary rehabilitation (19 grantees), and emergency room services or upgrades (17 grantees). The most frequently reported challenges to developing these outpatient services included: recruiting and retention problems, lack of funding, lack of support from other parties, and regulatory constraints.

C. PROGRESS OF 1993 GRANTEES

The 1993 grantees were on schedule with most of their project activities. Four grantees (two percent) reported completing all of their grant objectives within 6 months after grant award. (See Table IV.2.) In addition, 28 percent (46 grantees, not shown in table) completed at least one of their grant objectives during this time. The objectives grantees were most likely to complete during this period were coordinating with other providers and expanding support services. Almost half (43 percent) reported being at least on schedule with all of their grant objectives. Most grantees (55 percent) reported one or more objectives that were behind schedule by at least 1 month. None reported being behind on all grant objectives (not shown in table).

As in 1991 and 1992, a few 1993 grantees completed all of their grant objectives early. Four (two percent) reported implementing all grant project objectives within 6 months after grant award.[1] These grantees implemented the following projects: (1) home health care; (2) a primary care clinic; (3) a cardiac rehabilitation and fitness program; and (4) biomedical equipment maintenance and repair services for area hospitals. In comparison, three grantees in 1991 and two grantees in 1992 completed their grant objectives within 9 months after award (Cheh and Giggie 1994). In 1989 and 1990, none of the grantees reported implementing all of their grant objectives within 6 months (Cheh et al. 1991b). This pattern suggests that early

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[1] All four of these grantees applied for and received funds for the second year of the grant project. These grantees can use second-year funds to pay salaries or other ongoing costs of the services they implemented with their grants.

TABLE IV.2

PROJECT PROGRESS AFTER 6 MONTHS, BY OBJECTIVE:
1993 GRANTEES

Project Objective	Total Number of Active Projects	Percentage Completed	Percentage Ahead of Schedule	Percentage on Schedule	Percentage Behind by More than 1 Month
Expand Outpatient Services	113 [a]	10	3	58	30
Coordinate with Other Providers[b]	85	17	0	73	11
Recruit Providers	74 [c]	10	3	58	30
Training or Staff Development	71 [c]	4	1	73	21
Improve Management	62	5	3	74	18
Implement Prevention Services	60	7	2	77	15
Implement Community Care Services	59 [c]	10	7	60	22
Implement Social Services	52	6	2	77	15
Construction or Renovation	46 [c]	9	2	62	27
Expand Inpatient Services	34 [c]	9	0	46	45
Provide Transportation	34	12	0	62	26
Expand Support Services	24	17	0	75	8
Implement Other Patient Services	9	13	25	63	0
Convert Facility	6 [c]	0	0	83	17
Overall Grantee Progress	**168 [d]**	**2 [e]**	**0 [f]**	**43 [g]**	**55 [h]**

SOURCE: First Grantee Monitoring Report, 1993 grantees.

NOTES: Percentages may not total 100 percent because of rounding error. Only grantees that were still active at the end of 6 months and that submitted grant progress reports are included. Progress is defined by the project's most delayed activity. For example, a project that is on schedule in only one activity and ahead of schedule in all the rest is defined to be on schedule.

[a] Two grantees reported this objective but did not report progress on the schedule. As a result, the percentages are based on 111 grantees.

[b] This objective includes hospital consortia, as well as formal and informal networks.

(continued)

TABLE IV.2 (continued)

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[c] One grantee did not report progress on the schedule for each of these objectives.

[d] Two of the 170 active grantees did not report project progress. Another grantee reported objectives but did not report progress on the schedule. As a result, the overall grantee progress percentages are based on 167 grantees.

[e] Represents percentage that reported completing all grant objectives.

[f] Represents percentage that reported at least being ahead of schedule for all grant objectives.

[g] Represents percentage that reported at least being on schedule for all grant objectives.

[h] Represents percentage that reported being behind schedule by more than 1 month for one or more grant objectives.

implementation of grant objectives may be increasing, although the number of such grantees is small.

Early implementation of grant projects seemed to occur among grantees that had received previous RHCT grants and grantees that pursued projects with limited objectives. Two of the four 1993 grantees completing their projects early had received previous RHCT grants; this experience may have aided their completion of the 1993 projects. By proposing only one or two objectives, these four grantees were also able to focus their efforts on limited staff and activities and to implement their grants early.

One-quarter of the grantees implemented at least one of their objectives within 6 months after grant award (not shown in table). The grant objectives most likely to be implemented within this period were coordinating with other providers and expanding support services. (See Table IV.2.) Seventeen percent of the 85 grantees that planned to coordinate services with other providers completed this objective within 6 months. A sample of the activities that grantees reported implementing include forming advisory committees; coordinating with rural clinics, hospitals, businesses, and other groups to sponsor a mobile screening unit; and coordinating referrals among home health, mental health, physician, social work, and adult day care providers. In addition, 17 percent of the 24 grantees that planned to expand support services completed this objective within 6 months. Grantees' progress on most other grant objectives was slower. When asked about the reasons for their project success, they most frequently reported the availability of grant funds (109 grantees) and support from other parties (84 grantees), such as community financial assistance for Rural Health Clinics, shared resources among consortia members, and availability of other organizations to provide physical therapists or hospice trainers.

The 1993 grantees' adherence to schedules mirrors that of earlier grantees. Forty-five percent of the 1993 grantees reported completing or being on schedule with their grant projects, compared with 39 percent of the 1990 grantees and 53 percent of the 1989 grantees (Cheh et al. 1990 and 1991b). The remaining 55 percent of 1993 grantees, similar to earlier cohorts, reported being behind schedule by more than 1 month in at least one objective.

Not surprisingly, the most commonly delayed objectives and problems with implementation involved staffing or recruiting providers. Thirty percent of the 74 grantees that were recruiting providers reported delays of 1 month or more. In addition, 45 percent of the 34 grantees expanding inpatient services and 30 percent of the 113 grantees expanding outpatient services reported being behind schedule by more than 1 month. The most common reasons for these delays were staffing and recruiting problems. Overall, the most common problem grantees reported in implementing grant projects involved recruitment and retention of providers. In addition to the one-third (54 grantees) reporting provider recruitment and retention problems, one-quarter (45 grantees) reported lack of project personnel as a hindrance to grant progress. Other commonly reported problems with project implementation included lack of support from organizations outside of the hospital (44 grantees) and lack of funding (39 grantees).

D. PROJECT MODIFICATIONS

Another component of monitoring project progress is monitoring the modifications that grantees made to their projects. We identified project modifications for the 1993 grantees from two sources: (1) narrative responses to a question on the monitoring form about grant project changes; and (2) responses to a question on the project progress form about objectives that were added to or dropped from the project after the proposal was submitted to HCFA.

We assessed changes in grantees' projects by focusing on three aspects of their plans: (1) project goals; (2) specific objectives; and (3) activities. The goals represented the three major project orientations: (1) improving patient services; (2) improving management or staffing; and (3) modifying hospital facilities. Within each of these goals, grantees could pursue up to 14 specific objectives. Finally, grantees could undertake a variety of activities to achieve their objectives. Thus, a grantee might pursue the goal of improving management or staffing by pursuing the objective of recruiting. In turn, the grantee might try to recruit physicians or a quality assurance director.

In summarizing changes in grantees' projects, we focused primarily on changes in major goals. Many grantees changed specific objectives and activities, but only 12 of the 170 active grantees actually changed project goals. All of these 12 grantees added a goal to their grant projects after the proposal. Upon investigation, we found that eight of these grantees added a goal in order to complete their originally proposed project. For example, one added the goal of modifying hospital facilities in order to provide space for its originally proposed physical therapy unit. Only four grantees appear to have added activities that were substantially different from their originally proposed goals. For example, one hospital in South Dakota added wellness programs and Lifeline™ services to its original goals of improving management, staffing, and the hospital building. Another hospital in South Dakota added outpatient therapy to its original goal of improving management and staffing. A Kentucky hospital now pursues a rural health network in addition to its original goal of improving patient services, while a hospital in Wisconsin is converting hospital space, in addition to improving patient services, management, and staffing.

An additional 13 grantees dropped an activity from their projects after award. Although these grantees did not change their goals as described earlier, some of the dropped activities represented a large part of the original projects. The 13 grantees dropped the following activities: recruiting physicians and nurses, coordinating with other providers, and implementing outpatient services (such as respite care, a primary care or Rural Health Clinic, outpatient therapy, a wellness program, mammography services, community care services, and transportation).

E. GRANT EXPENDITURES

Grantees' expenditures for the first 6 months of the grant were consistent with the project progress they reported. In addition, overall spending remained well within the one-third limit on capital expenditures.[2] HCFA awarded a total of $8,012,086 to the 168 reporting grantees for the first year of their grants, an average of $47,691 per grantee. Six months after award, the 168 reporting grantees had spent approximately 40 percent ($3,219,704) of first-year funds, an average of $19,165 per grantee. Most likely, grantees spent less than half of their first-year funds during this period because many (55 percent) were behind schedule on at least one project objective.

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[2] See Omnibus Reconciliation Act of 1989, P.L. 239, Section 4005 (e).

The 1993 cohort spent a higher proportion of its first-year funding than the 1989 and 1990 cohorts. The 1989 and 1990 grantees had spent only 23 percent and 31 percent, respectively, of their first-year funds within 6 months after award, compared with the 1993 grantees, which had spent 40 percent of their first-year funds within this period (Cheh et al. 1990; and Cheh et al. 1991b). This finding suggests that the 1993 grantees may face fewer implementation delays; however, because we lack monthly budgets for comparisons, expenditures are not a valid measure of project progress.

For the 1993 grantees, only 18 percent of their expenditures went for equipment and capital. Only one grantee reported spending more than one-third of its total grant budget on equipment and capital. (This situation was reported to HCFA in an earlier document. This grantee reported all project expenditures, including those not funded by the RHCT grant.)

Similar to earlier grantees, grantees in 1993 reported spending more of their grants (43 percent) on salaries and fringe benefits than on any other category. Expenditures by category for the first 6 months of the grant included:

- Salaries and fringe benefits: $1,385,900 (43 percent)
- Equipment and capital: $580,505 (18 percent)
- Nonphysician contracts: $535,428 (17 percent)
- Physician contracts: $227,990 (7 percent)
- Travel: $124,969 (4 percent)
- Supplies: $116,433 (4 percent)

- Other: $248,479 (8 percent)[3]

Grantees that were pursuing objectives involving capital purchases or recruitment reported spending a larger proportion of their first-year funding than grantees pursuing other objectives. Grantees that made capital expenditures on construction projects could have spent their first-year funding quickly, although they may not have been able to report significant progress on their objectives until construction was completed. Four of the six grantees converting their hospitals to limited-service facilities reported spending more than 75 percent of their first-year funding at the end of 6 months. (See Table IV.3.) Yet, none of these grantees reported completing their grant projects or being ahead of schedule. (See Table IV.2.) Thirty-three percent of the 24 grantees expanding support services reported spending more than 75 percent of first-year funding after 6 months, and 17 percent of these grantees reported completing this objective after 6 months. (Grantees expanding support services often purchase radiology or laboratory equipment.) Twenty-four percent of the 46 grantees that were renovating their hospitals spent more than 75 percent of first-year funding within 6 months; 9 percent reported completing the objective.

Physician recruitment can also be an expensive and sometimes continuous effort. Almost one-quarter of the grantees that were recruiting providers spent more than 75 percent of their first-year funding; half as many reported completing this objective.

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[3] Percentages do not total 100 percent because of rounding error.

TABLE IV.3

PERCENTAGE OF FIRST-YEAR FUNDING SPENT DURING FIRST 6 MONTHS, BY GRANT OBJECTIVES

Project Objective	Number of Active Projects	Distribution of First-Year Funding Spent			
		0 to 25 Percent	25.1 to 50 Percent	50.1 to 75 Percent	More than 75.1 Percent
Expand Outpatient Services	113 [a]	33	32	16	19
Coordinate with Other Providers	85	40	29	14	16
Recruit Providers	74 [a]	28	26	24	22
Training or Staff Development	71	35	30	20	15
Improve Management	62	37	29	19	15
Implement Prevention Services	60	43	23	20	13
Implement Community Care Services	59	36	31	15	19
Implement Social Services	52 [b]	35	37	18	10
Construction or Renovation	46	35	26	15	24
Expand Inpatient Services	34	38	29	12	21
Provide Transportation	34 [b]	42	24	12	21
Expand Support Services	24	29	25	13	33
Implement Other Patient Services	9	44	22	22	11
Convert Facility	6	17	17	0	67
Total	**168**	**40**	**27**	**17**	**16**

SOURCE: First Grantee Monitoring Report, 1993 grantees.

NOTES: Percentages may not total 100 percent because of rounding error. Only grantees that were still active at the end of 6 months and submitted grant expenditure reports are included.

[a] Two of the grantees in each category reported this objective but did not report expenditures.

[b] One of the grantees in each category reported this objective but did not report expenditures.

V. 1994 GRANT SOLICITATION PROCESS AND APPLICANT CHARACTERISTICS

A. SOLICITING AND SCORING THE APPLICATIONS AND SELECTING GRANTEES

The Health Care Financing Administration (HCFA) solicited applications to the 1994 Rural Health Care Transition (RHCT) grants program by sending letters and application forms to approximately 2,800 rural, nonprofit hospitals. As in previous years, an eligible hospital had to be a non-Federal, nonproprietary, short-term, general acute-care hospital with fewer than 100 beds. It also had to be classified as a rural hospital under Medicare's prospective payment system.[1] Hospitals that received grants in 1992 or 1993 and accepted maximum grant funding for their continuation in 1994 were ineligible.[2] HCFA received applications from 346 hospitals: 266 submitted individual applications, and 80 hospitals submitted 20 applications as part of consortia.

Technical panels reviewed and scored the applications according to the following five criteria mandated by Congress:

1. Understanding of the problems facing the hospital
2. Likelihood of a successful impact resulting from the grant

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[1] P.L. 100-203, Section 4005(e).

[2] Because the 1989, 1990, and 1991 RHCT grantees had completed their grant projects. they were eligible to apply for the 1994 grants program. Any 1992 or 1993 grantee that gave up grant funding or received less than the maximum allowable amount was also eligible to apply for a 1994 grant. A total of eight 1989 grantees, eight 1990 grantees, thirty-one 1991 grantees, and one 1992 grantee received 1994 awards. No 1993 grantee received an award in 1994.

3. Potential for improving access to care
4. Degree of community coordination demonstrated
5. Potential to reduce Medicare expenditures

The panels submitted scores to HCFA in May 1994. The scores were then normalized using standard statistical techniques to account for panel variation.[3] HCFA selected grant award winners using the process described in Chapter I.

HCFA awarded 129 grants to 128 hospitals--98 grants to individual hospitals (2 grants to one hospital) and 31 grants to hospitals in 7 consortia. Slightly more than $5.6 million was awarded to the 128 grantees for fiscal 1994. The majority of the grants were for $50,000 per year for 3 years. The largest grant awards were for $150,000 over 3 years; the smallest award was $18,840 over 1 year. Appendix A lists the 1994 grantees and their first-year grants, by State.

B. GEOGRAPHIC DISTRIBUTION OF THE APPLICANTS

HCFA received applications from 346 hospitals for the 1994 RHCT grants program. (See Table V.1.) Only 18 percent of eligible hospitals nationwide applied.[4] Applications came from 44 of 46 states with eligible hospitals.[5]

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[3] See Appendix B for information on the score adjustment process.

[4] HCFA supplied counts of eligible hospitals by State. The total was 1,960 eligible hospitals, as shown in Table V.1.

[5] The two states with eligible hospitals, but no applicants for a 1994 RHCT grant, were Massachusetts (with two eligible hospitals) and Maryland (with three eligible hospitals). These figures exclude Puerto Rico, which had three eligible hospitals and no applicants.

TABLE V.1

GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION: 1994 ELIGIBLE HOSPITALS, PROPOSALS RECEIVED, AND AWARDS

Census Division and State	Number of Eligible Rural Hospitals	Percentage of Eligible Hospitals Nationwide	Number of Proposals Received	Number of Hospitals that Applied	Percentage of Eligible Hospitals that Applied	Number of Awards	Percentage of Eligible Hospitals Awarded at Grant	First-Year Funding Level ($)
New England								
Maine	17	0.87	3	3	17.65	1	5.88	42,800
Massachusetts	2	0.10	0	0	0.00	0	0.00	0
New Hampshire	11	0.56	2	2	18.18	1	9.09	37,500
Vermont	10	0.51	1	2	20.00	2	20.00	98,000
Total	40	2.04	6	7	17.50	4	10.00	178,300
Middle Atlantic								
New York	30	1.53	2	2	6.67	2	6.67	100,000
Pennsylvania	15	0.77	3	3	20.00	1	6.67	50,000
Puerto Rico	3	0.15	0	0	0.00	0	0.00	0
Total	48	2.45	5	5	10.42	3	6.25	150,000
South Atlantic								
Florida	23	1.17	1	1	4.35	1	4.35	50,000
Georgia	75	3.83	6	8	10.67	3	4.00	143,790
Maryland	3	0.15	0	0	0.00	0	0.00	0
North Carolina	42	2.14	11	12	28.57	2	4.76	100,000
South Carolina	18	0.92	2	2	11.11	1	5.56	50,000
Virginia	22	1.12	7	7	31.82	1	4.55	50,000
West Virginia	26	1.33	7	9	34.62	1	3.85	50,000
Total	209	10.66	34	39	18.66	9	4.31	443,790
East South Central								
Alabama	45	2.30	4	4	8.89	2	4.44	82,983
Kentucky	49	2.50	6	6	12.24	2	4.08	100,000
Mississippi	68	3.47	11	11	16.18	3	4.41	150,000
Tennessee	49	2.50	5	5	10.20	2	4.08	99,320
Total	211	10.77	26	26	12.32	9	4.27	432,303

TABLE V.1 *(continued)*

Census Division and State	Number of Eligible Rural Hospitals	Percentage of Eligible Hospitals Nationwide	Number of Proposals Received	Number of Hospitals that Applied	Percentage of Eligible Hospitals that Applied	Number of Awards	Percentage of Eligible Hospitals Awarded a Grant	First-Year Funding Level ($)
West South Central								
Arkansas	47	2.40	10	10	21.28	3	6.38	118,840
Louisiana	56	2.86	6	6	10.71	2	3.57	100,000
Oklahoma	69	3.52	9	9	13.04	4	5.80	200,000
Texas	177	9.03	12	12	6.78	8	4.52	400,000
Total	349	17.81	37	37	10.60	17	4.87	818,840
West North Central								
Iowa	91	4.64	18	19	20.88	5	5.49	249,891
Kansas	102	5.20	10	10	9.80	6	5.88	299,915
Minnesota	95	4.85	25	27	28.42	10	10.53	475,395
Missouri	53	2.70	10	15	28.30	3	5.66	150,000
Nebraska	74	3.78	13	32	43.24	11	14.86	129,000
North Dakota	40	2.04	3	3	7.50	2	5.00	100,000
South Dakota	49	2.50	7	15	30.61	3	6.12	118,100
Total	504	25.71	86	121	24.01	40	7.94	1,522,301
East North Central								
Illinois	57	2.91	12	13	22.81	4	7.02	149,630
Indiana	31	1.58	5	5	16.13	2	6.45	100,000
Michigan	56	2.86	8	9	16.07	3	5.36	146,000
Ohio	32	1.63	2	2	6.25	1	3.13	50,000
Wisconsin	57	2.91	13	13	22.81	4	7.02	189,815
Total	233	11.89	40	42	18.03	14	6.01	635,445
Mountain								
Arizona	28	1.43	3	3	10.71	1	3.57	50,000
Colorado	41	2.09	5	5	12.20	2	4.88	99,234
Idaho	34	1.73	5	5	14.71	2	5.88	100,000
Montana	47	2.40	5	9	19.15	2	4.26	98,676
Nevada	11	0.56	1	1	9.09	1	9.09	48,200
New Mexico	26	1.33	5	5	19.23	1	3.85	48,012
Utah	19	0.97	2	10	52.63	10	52.63	368,850
Wyoming	20	1.02	3	3	15.00	2	10.00	50,000
Total	226	11.53	29	41	18.14	21	9.29	862,972

TABLE V.1 *(continued)*

Census Division and State	Number of Eligible Rural Hospitals	Percentage of Eligible Hospitals Nationwide	Number of Proposals Received	Number of Hospitals that Applied	Percentage of Eligible Hospitals that Applied	Number of Awards	Percentage of Eligible Hospitals Awarded a Grant	First-Year Funding Level ($)
Pacific								
Alaska	18	0.92	5	5	27.78	1	5.56	49,891
California	47	2.40	5	8	17.02	4	8.51	200,000
Hawaii	8	0.41	1	1	12.50	1	12.50	50,000
Oregon	29	1.48	7	7	24.14	3	10.34	150,000
Washington	38	1.94	7	7	18.42	3	7.89	150,000
Total	140	7.14	25	28	20.00	12	8.57	599,891
National Total	**1,960**	**100.0**	**288** [a]	**346**	**17.65**	**129**	**6.58**	**5,643,842**

SOURCE: National Biosystems.

[a] The number of proposals received actually equals 286, because 2 proposals were received from consortia, and each of these proposals included two hospitals from separate states. These proposals were included in the counts for each state.

The highest application rate occurred in the West North Central census division, in which 24 percent of eligible hospitals applied.[6] Two states in this division, Nebraska (in which 43 percent of eligible hospitals applied) and South Dakota (in which 31 percent of eligible hospitals applied), are largely responsible for this high rate. Nebraska, with 74 eligible hospitals, also had the most hospitals apply (32, of which 19 were in consortia). Elsewhere, 35 percent of eligible hospitals in West Virginia applied for grants.

The Essential Access Community Hospital and Rural Primary Care Hospital (EACH/RPCH) Program may account for the high application rates in South Dakota and West Virginia. These states are members of the seven-state EACH/RPCH Program, which may have generated additional information about or interest in the RHCT grants program in these two states. In addition, small primary care hospitals may have been able to apply to the transition grants program because their alliance with larger essential access community hospitals afforded them access to additional resources, such as experienced grant-writing staff.

Alternatively, the high rate of successful grant application in 1989 may have enhanced application rates in South Dakota and West Virginia since then. The success rate for applicants from these states was fairly high in 1989 (22 and 33 percent). Application rates have been high ever since despite much lower award rates. In contrast, Texas had a high application rate in 1989 but a relatively low award rate; the application rate in subsequent years fell steadily afterward. (See Cheh et al. 1990; Cheh et al. 1991a; Giggie et al. 1993; and Bergeron et al. 1994.)

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[6] In addition, 23 percent of the eligible hospitals in this census division already had grants continuing beyond 1994.

The lowest application rate occurred in the Middle Atlantic census division, in which 10 percent of eligible hospitals applied. Even after we accounted for the hospitals in this division that already had grants continuing past 1994 (13 percent), only 23 percent of eligible hospitals either applied for or had RHCT grants in 1994.

Elsewhere, some individual states had low or zero application rates but a large proportion of eligible hospitals. None of the five eligible hospitals in two states (Massachusetts and Maryland) applied to the grant program in 1994. Other states with low application rates included Florida (four percent), Ohio (six percent), Texas (seven percent), North Dakota (eight percent), and Alabama and Nevada (nine percent each). With the exception of Nevada, in which 90 percent of the eligible hospitals were already funded past 1994 with RHCT grants, no more than 23 percent of eligible hospitals in these states had grant funding past 1994, and no more than 9 percent applied. As a result, at least 68 percent of the eligible hospitals in these five states (excluding Nevada) chose not to apply for a RHCT grant in 1994.

C. FEDERAL AND EXTERNAL FUNDING AND LOCAL COOPERATION

1. Federal Funding

Most of the 346 hospitals that applied to the 1994 RHCT grants program requested 3 years of funding. Overall, for the total 3-year grant period, applicants requested an average of $42,547 in Federal funding. They requested an average of $44,845 for the first year, $41,995 for the second year, and $40,803 for the third year. Funding requests for the second and third years were lower than those for the first year for two reasons: (1) some hospitals planned to complete their projects in fewer than 3 years; and (2) some hospitals expected their project revenues to increase during the 3-year period, offsetting their need for Federal subsidies.

HCFA awarded a total of $5,643,842 for the first year of the 129 grants, an average of $43,751 per grant. State grant pools accounted for $5,001,522 in awards to 113 hospitals. The national pool accounted for $642,320 in awards to 16 hospitals.

2. External Funding

HCFA encouraged grant applicants to seek external funding to complement grant funds and asked hospitals to document in their applications any external funding they expected for their projects. HCFA instructed grant review panels to consider external project funding as evidence of community coordination and to rank applicants with strong community coordination higher than others. Having external funding increased the likelihood that proposed projects would receive Federal funds.

Typical sources of external funding reported by applicants were the hospital itself and the hospital auxiliary. Many hospitals indicated that they intended to supplement grant funds with funds they had already committed to the project or with funds that would be committed if they received a grant. Typically, nongrant monies were slated for equipment purchases needed for a project, because equipment costs often exceeded the one-third capital budget limit imposed by Congress on grant expenditures.

Another common source of proposed external funding was project revenue. Some hospitals made revenue projections and indicated that these revenues would be used to fund future project costs. Other hospitals indicated that they expected project revenues to make up the difference between expected costs and the amount requested from the grants program.

As expected, a smaller proportion of funded proposals than nonfunded ones anticipated no external funding. (See Table V.2.) Four of the 105 funded ones (4 percent) proposed no external funding; 20 of the 181 nonfunded proposals (11 percent) proposed no external funding.[7] The broad definition of external funding, the various methods hospitals use to quantify in-kind support, and the softness of funding commitments suggest caution in interpreting data provided by hospitals on this topic.

D. COMPARISON OF APPLICANTS FROM 1989 THROUGH 1994

The number of 1994 applicants (346) was the lowest since the RHCT grants program began and was half the number that applied during the first program year (1989). (See Table V.3.) The change reflects a gradual and consistent decrease in applicants between 1989 and 1994. This decrease was the result of three factors:

1. The pool of eligible hospitals was smaller because hospitals that were awarded grants in either 1992 or 1993 and received maximum continuation grant funding in 1994 could not immediately benefit from a 1994 award, and hence had limited incentive to apply.[8]

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[7] Among the grantees, each of 7 consortia submitted a proposal, and other grantees submitted 98 proposals. Thus, HCFA approved the proposals of 105 hospitals.

[8] Hospitals with maximum funding in 1994 from a 1992 or 1993 grant could secure future grant financing by receiving a 1994 award (and giving up an earlier grant).

TABLE V.2

EXTERNAL FINANCING OF FUNDED AND NONFUNDED PROPOSALS, 1994 APPLICANTS

	Funded Proposals	Nonfunded Proposals
Median Value of External Financing	$108,170	$136,861
Maximum Value of External Financing	$6,177,702	$6,072,850
Number of Proposals with No External Financing	4	20
Total Number of Proposals	**105**	**181**

SOURCE: National Biosystems.

TABLE V.3

DISTRIBUTION OF GRANT APPLICANTS, BY REGION: 1989 THROUGH 1994

	1989	1990	1991	1992	1993	1994
Number of Applicants	704	502	445	387	394	346
Average Annual Funding Requested (Dollars)	43,398 [a]	39,889	40,336	39,799	44,412	42.547
Percent Distribution, by Region						
Northeast	6	3	4	2	4	4
Midwest	36	51	46	47	46	47
South	40	29	30	28	31	30
West	18	17	20	23	19	20

SOURCE: National Biosystems.

[a] Applicants in 1989 requested funds only for a 2-year period because of the program's 2-year limitation at the time. Applicants in later years could request funds for a 3-year period.

2. Some previous applicants that were not awarded grants became discouraged and did not apply again in 1994.

3. The pool of hospitals that had never applied for an RHCT grant was shrinking.

Beginning in 1991, grant applications for the Federal Rural Health Outreach Grant Program were also due at approximately the same time as RHCT applications (March of each year). Some small hospitals may have lacked the resources to apply for both programs and may have opted to forgo applying for the RHCT grants program.

The average annual grant funding requested per applicant was $42,547 during 1994, in the middle of the range of average annual grant funding requests for the 6 years of the program. The lowest average annual grant funding per applicant occurred in 1992, when applicants requested an annual average of $39,799 (a total of $119,378 during a 3-year period). The highest average annual grant funding requested was $44,412 in 1993 (a total of $133,236 during a 3-year period).

Since the RHCT grants program began in 1989, applications from the South census region have decreased and applications from the Midwest census region have increased. (See Table V.3.) The proportion of applicants from the South census region fell from 40 percent in 1989 to 29 percent in 1990. This proportion has remained between 28 and 31 percent, about 9 percentage points less than would be expected on the basis of the proportion of eligible hospitals in the region (40 percent). Conversely, the proportion of applicants from the Midwest census region increased from 36 percent in 1989 to 47 percent in 1994, approximately 9 percent higher than the proportion of eligible hospitals from that region (38 percent). The proportion of applicants from the West census region fluctuated somewhat, from a low of 17 percent in 1990 to a high of 23 percent in 1992. In 1994, 20 percent of applicants came from the West census region in proportion to the percentage of eligible hospitals from that region (19 percent). The proportion of applicants from the Northeast census region remained approximately proportional to the percentage of eligible hospitals (four percent).

E. COMPARISON OF GRANTEES FROM 1989 THROUGH 1994

Comparing awards across the 6 years of the RHCT grants program shows that the number of grantees declined, from a high of 212 grantees in 1990 to the present low of 129 grantees in 1994 (a decrease of 39 percent). Average first-year funding fluctuated between $42,059 in 1992 and $47,959 in 1993, in response to the availability of grant funding during the 6 years of the RHCT grants program.

The geographic distribution of grantees represents two factors: (1) the number of applicants by region; and (2) HCFA's intention to create regional balance in the program (thus, the regional distribution of grant awards generally represents the regional distribution of eligible hospitals). (See Table V.3 and Table V.4.) The proportion of awards in the Northeast varied between three and eight percent, with five percent in 1994. The proportion of awards in the Midwest varied between 40 and 47 percent, with 42 percent in 1994. The proportion of awards in the South fell from 34 percent of the total in 1989 to 23 percent in 1992, which is consistent with the decline in applications from the South during those years, but then increased to 27 percent in 1994. In the West, the percentage of awards reflected the changes in the percentage of applications from that region, except in 1992 and 1994, when

TABLE V.4

COMPARISON OF AWARDS, BY REGION: 1989 THROUGH 1994 GRANTEES

	1989	1990	1991	1992	1993	1994
Number of Grantees	184	212	187	163	178 [a]	129
Average First-Year Funding Amount (Dollars)	44,861	44,212	43,708	42,059	47,959	43,751
Percent Distribution by Region						
Northeast	8	3	6	5	3	5
Midwest	40	46	47	43	45	42
South	34	33	29	23	31	27
West	19	18	18	29	21	26
Number of Consortia Projects	11	16	14	10	13	7
Percentage of Grantees in Consortia	21	29	26	28	28	24

SOURCE: National Biosystems.

[a] The total number of approved applications in 1993 was 179. The 1993 application for Orange City Hospital in Iowa was approved by HCFA but not funded.

these percentages rose to 29 percent and 26 percent, respectively. This pattern can be partially explained by awards to a consortium of seven hospitals in Nevada in 1992 and a consortium of seven hospitals in Utah in 1994.

The percentage of grantees in funded consortium projects was 24 percent in 1994. The percentage in consortia has fluctuated between 24 percent and 28 percent over time.

VI. DOES A LOW-INCOME LOCATION AFFECT HOSPITALS' FINANCIAL STABILITY?

Hospitals' dual interest in serving the community and remaining financially viable--that is, balancing their mission with their margin--is strikingly evident among the grantees in poor areas. Many of these hospitals face serious financial challenges, and equally serious health care needs exist in their communities. In interviews with 37 grantee hospitals located in poor counties, we found that only about half used the grant money to improve their financial health. Instead, many used the money to pursue efforts targeted at improving community health. In general, the hospitals in low-income areas appear to have remained financially viable through a mixture of balanced operations, revenues from local government, and special reimbursements from Medicare and Medicaid. Given this underlying level of support, the grants give these hospitals the means for improving their ability to serve their communities (albeit on a temporary basis) while minimizing the additional strain on their resources.

The 37 interviewed hospitals (20 of the 1992 and 17 of the 1993 grantees) are located in the counties with the lowest per-capita income among grantees. A number of factors affect the financial survival of these institutions, including the characteristics of their local economies, management characteristics of the hospital, and government and community support. In this chapter, we explore how each of these factors affects the financial stability of the interviewed hospitals. We conclude by examining the role individual grant projects play in both the margin and the mission of the hospitals.

A. CHARACTERISTICS OF LOCAL ECONOMIES

Most of the interviewed grantees are in the South and in significantly poorer counties than the average grantee. Two-thirds are in the South, with a substantial minority (one-quarter) in the West, primarily New Mexico. This is a substantially higher distribution of Southern states than among the cohort overall--only 27 percent of all 1992 and 1993 grantees are in this region. (See Table V.4.) Per-capita income in the interviewed hospitals' counties averaged $10,755 in 1990, more than 30 percent lower than in counties with small rural hospitals nationwide.

The income base of the local economies includes a diverse range of industries. Just over half (20) reported small manufacturing in their economies. Often, these communities include one or two small companies, such as a food processing plant, that generate the majority of area jobs. Another 14 depend on agriculture, such as corn and cotton crops, as a major source of income. Several interviewees are located in declining mining communities, and they describe area employment as fluctuating along with the price of copper or simply dissipating as a result of mine closings. Correctional facilities are also a common employer; six of these areas rely on a federal or state prison for jobs, and several more report prisons being built. Seven of these areas have no significant private employer or main source of income, naming only the hospital, local government, or the school system as major employers.

The majority of these grantees describe their local economy as fairly static. Twenty four report no changes in the local economy during the past 5 years, and 23 do not expect changes in the near future. As one grantee remarked, "Our economy is doing relatively well at a very low level. We've never had a high level of economic activity here." Some of these hospitals (14), however, are optimistic about their community's future, citing new business and expected industrial growth.

B. CHARACTERISTICS OF THE GRANTEE HOSPITALS IN LOW-INCOME COUNTIES

1. Hospital Size and Management

The interviewed hospitals vary in size and management characteristics but are generally representative of all 1992 and 1993 grantees. The typical low-income hospital has 34 staffed beds; the median number of staffed beds for all 1992 and 1993 grantees is 31. (See Table II.6.) Only a minority have an outside management contract (30 percent), but a majority are public hospitals (56 percent), again similar to the cohort overall (27 percent with outside management contracts and 56 percent public). (See Table II.1.) Twenty-seven percent belong to a multihospital system, about 10 percentage points higher than for the overall group of grantees. (See Table II.1.)

2. Payer Types and Degree of Uncompensated Care

Medicaid recipients are a sizable portion of these grantees' patients. On average, the hospitals interviewed drew 20 percent of their operating revenue from Medicaid patients, with some drawing more than 50 percent. This figure is higher than that for the average small rural hospital, which in 1992 had about a 15 percent Medicaid patient base (Health Care Investment Analysts, Inc., and Deloitte & Touche 1993). One hospital noted that more than three-quarters of the people in its service area receive public assistance.

The interviewed hospitals also provide large amounts of uncompensated care. Uncompensated care averages an amount equivalent to 11 percent of operating revenue for these grantees; in other words, more than 11 percent of these hospitals' charges are never paid.[1] This level of uncompensated care is larger than that for the average rural hospital, which reports only about five percent of hospital costs as uncompensated care (Prospective Payment Assessment Commission 1993).[2] Several hospitals have all but given up hope of ever reducing the amount of uncompensated care they provide.

3. Financial Status

Surprisingly, although these hospitals are located in significantly poorer communities than the average grantee, their financial status is not markedly different from that of other grantees. Thirteen had a positive operating margin during the past 3 years, 10 broke even, and 14 reported a loss. The median operating margin for all 1992 and 1993 grantees at the time of grant award was negative one percent, a roughly comparable number. (See Table II.2.)

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[1] The uncompensated care figure includes both bad debt and charity care; the figure excludes contractual adjustments for Medicare, Medicaid, and other payers.

[2] The two statistics being compared here are calculated differently. We calculate uncompensated care as a percentage of hospital operating revenue, but the Prospective Payment Assessment Commission calculates it as a percentage of total hospital costs. Even with this difference in calculation method, however, the gap between the two numbers suggests that a larger amount of uncompensated care is delivered in the interviewed hospitals. In the interviewed hospitals, operating revenues would need to be less than half of total hospital costs in order for the two figures to suggest similar levels of uncompensated care. For the 1993 grantees, the mean ratio of hospital operating revenues to total hospital costs was .98; substantially higher than the one-half ratio.

Hospitals that are in poor financial shape tend to be smaller and to have high levels of uncompensated care. The mean number of staffed beds for hospitals with a positive operating margin is 43; those with a negative operating margin average 37 beds. The percentage of uncompensated care provided in hospitals that lose money on operations is 5 percent higher (13 percent versus 8 percent) than in hospitals that make money on operations.

C. HOW DO THESE HOSPITALS SURVIVE FINANCIALLY?

Despite the draining effects of a low-income location, one-third of these hospitals are able to maintain a positive operating margin without direct subsidies from local government, the community, or a multihospital system. Of the 24 hospitals that have a negative operating margin or are breaking even, 16 rely on local or state tax dollars for financial stability. Seven of the 24 grantees also use disproportionate share payments to secure the hospital. Only two receive pivotal financial support from community donations or a multihospital system. Finally, 6 of these 24 hospitals receive no significant financial support from outside sources. Most of these grantees are breaking about even, and they have enough financial reserves to keep the hospitals afloat.

1. Sources of Financial and Other Support

a. County and State Government

Local tax support is a key factor in the financial stability of many interviewed grantees. About half receive funds from state or local government, typically a levy collected from the local community and usually exceeding $100,000 per year. Of the 24 interviewed hospitals that did not make a profit on operations, 16 receive this type of support from local or state government. Conversely, only two of the hospitals with a positive operating margin receive these funds.

b. Disproportionate Share Payments

Disproportionate share payments are another form of government financial support for the interviewed hospitals. The majority of these hospitals (22 of the 37) are classified as disproportionate share hospitals, indicating their relatively large proportion of low-income patients.[3] Seven hospitals cited disproportionate share payments as an important means of financial support, with payments ranging from $70,000 to more than $800,000 a year. However, disproportionate share payments at half of these seven hospitals have been reduced or eliminated in the past 2 years.[4] A comparison of the dollar amount of these reductions to the amount the hospitals lose on operations in a typical year reveals that the reductions will have a significant impact on the hospitals' financial future.

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[3] Under the prospective payment system, hospitals are classified as disproportionate share when they serve a relatively large volume of low-income patients. This volume is calculated on the basis of the hospital's percentage of inpatient days attributable to Federal Supplemental Security Income Medicare beneficiaries and the percentage attributable to Medicaid patients. These hospitals receive additional payments from the Medicare and Medicaid program based on this status (U.S. House of Representatives 1994).

[4] Several hospitals lost their disproportionate share funding because they had discontinued obstetrical services, which some states require as part of disproportionate share eligibility. Other grantees had their funding cut because of statewide health financing reforms.

c. Membership in a Multihospital System

A number of the interviewed grantees are part of a larger multihospital system. However, the majority of these hospitals did not receive subsidies from their hospital system. Of the 10 that belong to a larger hospital system, only 2 are actually subsidized by the system when they lose money. Despite the lack of subsidies, most hospitals report benefits from their system, citing technical assistance, aid in physician recruitment, and financial benefits in investments and purchasing as advantages of affiliation with a larger system.

d. Direct Community Support

The majority of these hospitals receive very few community donations and only minimal in-kind support. Many grantees noted that their communities are simply too poor and too preoccupied with basic survival to support the hospital in financial or other ways. In fact, 27 of the interviewed grantees receive less than $5,000 a year in community donations. Of the 10 hospitals that do receive more than $5,000 a year in donations, 9 already make a profit on operations. Community donations are strengthening the hospitals that already have a positive operating margin, but they are not contributing to the survival of financially weak institutions.

D. GRANT PROJECT

Despite the fact that the grant program was designed to enhance rural hospital financial stability, many of the interviewed grantees did not design their grant projects to strengthen their financial base. Sixteen of the grant projects were designed solely to meet community need and without regard for the impact on hospital finances. Another 16 of the hospitals considered both community need and financial benefits in designing their projects. Only the remaining five chose projects designed specifically to bolster the hospital financial base.

Not surprisingly, the majority of the implemented grant projects are not expected to be self-supporting once the grant project ends. Only 15 are generating enough revenue to cover their costs. The remaining 22 projects will require additional hospital resources to continue after the grant program ends.

The non-self-supporting projects were typically created to meet a community need. For example, one hospital had a 50 percent no-show rate for medical appointments. It used the grant to create a patient transportation system to ensure that people in its service area could reach their appointments; the hospital does not charge for this service. Another hospital had participated in a recent countywide health planning effort, and it used the grant to develop one of the recommendations from that effort--an information center for seniors. The hospital intended for this center to serve as a clearinghouse of information on local services for the elderly. Again, there is no charge for this service. Another grantee contracted with a tertiary-care center to provide specialty services; these services are offered to area residents free of charge, as long as they are referred by their primary physician. While the services are well utilized, the hospital doubts that patients would be able or willing to pay for them if it discontinued its subsidization. In addition, two hospitals implemented geriatric case management programs. Both describe their projects as extremely valuable. The case management staff members monitor the health status of elderly patients and arrange for necessary care. Not only does this service meet the health needs of the patients, but it reduces the risk that serious conditions will go untreated and lead to long and expensive hospital stays. Despite their value to the community and hospital, the case management services require subsidization because most patients are too poor to pay for them and Medicare does not cover case management.

Although the majority of the grant projects do not directly affect hospital finances, most interviewed hospitals described the grant program as important to their hospitals' long-term survival. Many felt that the grant project helped position them for the future, allowing them to explore changes in health care delivery and developing their focus on community health rather than just medical care.

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APPENDIX A

FIRST-YEAR FUNDING UNDER THE GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION, 1994

TABLE A.1

FUNDS AWARDED UNDER GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION, 1994

State	Hospital Name (Consortium Number)	First-Year Funding (Dollars)
AK	Valdez Community Hospital	49,891
AL	Marion County Medical Center	50,000
AL	Vaughan Perry Hospital & Nursing Home	32,983
AR	Delta Memorial Hospital	50,000
AR	Eureka Springs Hospital	18,840
AR	Medical Center of Calico Rock	50,000
AZ	Northern Cochise Community Hospital	50,000
CA	Indian Valley District Hospital (#14)	50,000
CA	Mayers Memorial Hospital District (#14)	50,000
CA	Modoc Medical Center (#14)	50,000
CA	Surprise Valley Hospital District (#14)	50,000
CO	Kremmling Memorial Hospital	49,234
CO	Southeast Colorado Hospital & LTCC	50,000
FL	Doctor's Memorial Hospital	50,000
GA	Calhoun Memorial Hospital	50,000
GA	Crisp Regional Hospital	50,000
GA	Gordon Hospital	43,790
HI	Wilcox Memorial Hospital	50,000
IA	Cass County Memorial Hospital	49,891
IA	Hamilton County Public Hospital	50,000
IA	Horn Memorial Hospital	50,000
IA	Palo Alto County Hospital	50,000
IA	Van Buren County Hospital	50,000
ID	Bingham Memorial Hospital	50,000
ID	Gritman Medical Center	50,000
IL	Marshall Browning Hospital (#1)	25,000

TABLE A.1 *(continued)*

State	Hospital Name (Consortium Number)	First-Year Funding (Dollars)
IL	Pinckneyville Community Hospital (#1)	25,000
IL	John and Mary E. Kirby Hospital	49,630
IL	Richland Memorial Hospital	50,000
IN	Jennings Community Hospital, Inc.	50,000
IN	Perry County Memorial Hospital	50,000
KS	Graham County Hospital	50,000
KS	Hays Medical Center	50,000
KS	Maude Norton Memorial City Hospital	50,000
KS	Neosho Memorial Regional Medical Center	50,000
KS	Sabetha Community Hospital	49,915
KS	Southwest Medical Center	50,000
KY	Knox County Hospital	50,000
KY	Twin Lakes Regional Medical Center	50,000
LA	St. Helena Parish Hospital	50,000
LA	West Feliciana Parish Hospital	50,000
ME	Maine Coast Memorial Hospital	42,800
MI	Charlevoix Area Hospital	50,000
MI	Mecosta County General Hospital	46,000
MI	Tawas St. Joseph Hospital, Inc.	50,000
MN	Arnold Memorial Hospital (#4)	50,000
MN	Luverne Community Hospital (#4)	50,000
MN	Greater Staples Hospital	50,000
MN	Jackson Municipal Hospital	37,745
MN	Murray County Memorial Hospital	37,650
MN	Riverwood HealthCare Center	50,000
MN	Saint Elizabeth's Hospital & Nursing Home	50,000
MN	St. Peter Community Hospital	50,000
MN	Waseca Area Memorial Hospital	50,000
MN	Watonwan Memorial Hospital	50,000

TABLE A.1 *(continued)*

State	Hospital Name (Consortium Number)	First-Year Funding (Dollars)
MO	Pemiscot Memorial Hospital	50,000
MO	Pike County Memorial Hospital	50,000
MO	Putnam County Memorial	50,000
MS	District II Community Hospital	50,000
MS	George County Hospital	50,000
MS	Tyler Holmes Memorial Hospital	50,000
MT	Granite County Memorial Hospital	48,731
MT	Teton Medical Center	49,945
NC	Alleghany Memorial Hospital	50,000
NC	Crawley Memorial Hospital, Inc.	50,000
ND	Ashley Medical Center	50,000
ND	Wishek Community Hospital	50,000
NE	Antelope Memorial Hospital (#20)	7,900
NE	Brown County Hospital (#20)	7,900
NE	Cherry County Hospital (#20)	7,900
NE	Lundberg Memorial Hospital (#20)	7,900
NE	Niobrara Valley Hospital (#20)	7,900
NE	Osmond General Hospital (#20)	7,900
NE	Plainview Public Hospital (#20)	7,900
NE	Rock County Hospital (#20)	7,900
NE	St. Anthony's Hospital (#20)	7,900
NE	West Holt Memorial Hospital (#20)	7,900
NE	Brodstone Memorial Nuckolls County Hospital	50,000
NH	Speare Memorial Hospital	37,500
NM	DeBaca General Hospital	48,012
NV	Elko General Hospital	48,200
NY	Margaretville Memorial Hospital	50,000
NY	Soldiers and Sailors Memorial Hospital of Yates County	50,000

TABLE A.1 *(continued)*

State	Hospital Name (Consortium Number)	First-Year Funding (Dollars)
OH	Joel Pomerene Memorial Hospital	50,000
OK	Beaver County Memorial Hospital	50,000
OK	Mary Hurley Hospital	50,000
OK	Watonga Municipal Hospital	50,000
OK	Wetumka General Hospital Authority	50,000
OR	Curry General Hospital	50,000
OR	Hood River Memorial Hospital	50,000
OR	Lake District Hospital & Long Term Care Facility	50,000
PA	Memorial Hospital and Skilled Nursing Unit	50,000
SC	Hampton General Hospital	50,000
SD	Landmann-Jungman Memorial Hospital	50,000
SD	St. Benedict Health Center	25,000
SD	St. Michael's Hospital	43,100
TN	City of Milan Hospital	50,000
TN	Hickman County Health Services, Inc.	49,320
TX	Columbus Community Hospital	50,000
TX	Cuero Community Hospital	50,000
TX	Decatur Community Hospital	50,000
TX	Frio Hospital	50,000
TX	Highland Lakes Medical Center	50,000
TX	Hill Country Memorial Hospital	50,000
TX	Panola General Hospital	50,000
TX	Parkview Regional Hospital	50,000
UT	Central Valley Medical Center (#13)	49,450
UT	Gunnison Valley Hospital (#13)	49,450
UT	Milford Valley Memorial Hospital (#13)	49,450
UT	Allen Memorial Hospital (#16)	31,500
UT	Beaver Valley Hospital (#16)	31,500
UT	Duchesne County Hospital (#16)	31,500

TABLE A.1 *(continued)*

State	Hospital Name (Consortium Number)	First-Year Funding (Dollars)
UT	Kane County Hospital (#16)	31,500
UT	Monument Valley Hospital (#16)	31,500
UT	San Juan Health Care Center (#16)	31,500
UT	Tooele Valley Regional Medical Center (#16)	31,500
VA	Southside Community Hospital	50,000
VT	Copley Hospital, Inc. (#12)	49,000
VT	Gifford Medical Center (#12)	49,000
WA	Community Home Health/Hospice	50,000
WA	Lincoln County Public Hospital District #1	50,000
WA	Mid-Valley Hospital	50,000
WI	Door County Memorial Hospital	50,000
WI	Northwoods Hospital Association, Inc.	50,000
WI	Sacred Heart Hospital	40,000
WI	Sauk Prairie Memorial Hospital	49,815
WV	Grant Memorial Hospital	50,000
WY	South Lincoln Medical Center	22,500
WY	South Lincoln Medical Center	27,500

APPENDIX B

SCORE ADJUSTMENT PROCESS

This appendix documents how the scores of 1994 grant applications were adjusted to account for differences in panels' scoring, as well as how the adjusted scores were rescaled for easier interpretation. This work was done under Federal contract by National Biosystems.

To adjust the scores, the mean and standard deviation of the total scores for all proposals reviewed by each panel were calculated. Next, the panel mean was subtracted from each individual score, and this difference was divided by the panel standard deviation. Define X_{ip} as the individual proposal score assigned by the panel, X_p as the mean of all scores X_{ip} for that panel, and S_p as the standard deviation of the panel mean. The adjusted score (T_{ip}) is then calculated as:

$$(1) \quad T_{ip} = (X_{ip} - X_p)/S_p.$$

To rescale the adjusted scores so that they are easier to interpret, the maximum adjusted score and minimum adjusted score across all applicants were first identified. Define T_{max} as the maximum score, and T_{min} as the minimum. The rescaled score is then calculated as:

$$(2) \quad Score = \frac{T_i - T_{min}}{T_{max} - T_{min}} * 100.$$

This rescaling process resulted in scores that range from 0 to 100, the same as the original range of the panel-assigned scores. The process maintained the distribution and ranking of the adjusted scores.

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